Early Tuberculosis in Children

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TEN years ago, attention would have been directed to the early diagnosis of tuberculosis in adults, and while there is still much need for further emphasis on this subject, it would seem to be more opportune at the present time to direct attention to the earlier diagnosis of tuberculosis in children, since it is now conceded that the majority of cases of tuberculosis in adults are developments from infection in childhood.

During the first two years of life about 10% of children are infected; at three years about 15 or 20% are infected; at five years about 50% of children are infected; at six years 60%; at 15 years 75% or more. Thus but 25% or less of the young people of the country are left to be subject to the first infection by the tubercle bacillus at any time during adult life.

In tuberculous families further infection takes place as a rule *in the home* before three years of age. In non-tuberculous families infection takes place as a rule *out of the home* after three years of age.

In the case of suspected tuberculosis in an adult, attention is attracted by a persistent cough, a loss of weight, haemoptysis, or an abnormal temperature as the outstanding symptom. Usually, the patient has been ill too long to be suffering from an acute affection such as a common cold, and one immediately thinks of either a pathological condition of the upper respiratory passages or one of the intrathoracic organs of respiration. Both lines of investigation should be followed.

In tuberculosis in children, however, it is well to remember that as a rule there is no such definite lead as in the case of adults. Signs much less apparent should therefore be recognized as reasons for investigation. It is quite true that the adult type of disease is sometimes seen in children; but these are always advanced cases, in which the prognosis is uniformly bad.

As a rule the earliest manifestation of tuberculosis in the child is essentially as a disease of the lymphoid tissue. In the lungs there are two sets of lymphatics—the superficial and the deep. These form a network accompanying the branches of the blood vessels and bronchi throughout the lung tissue. These two systems are connected, and the different trunks thus formed converge in the lymph nodes of the hilum of the lung. These lymph nodes at the hilum are exposed to infection by tubercle bacilli, by whatever route these have gained access to the body. There are, of course, three common methods of infection:—(1) inhalation, (2) ingestion, and (3) inocculation.

(1) Inhalation.—The membrane of the alveoli is in contact with the inspired air. Any bacteria that gain an entrance by this method may be conveyed to the lymph channel and subsequently become arrested in the tracheo-bronchial lymph nodes, as all drainage from the lungs must pass through these filters.

(2) Ingestion—Bacteria taken in by way of the mouth, through any

part of the intestinal tract, will ultimately find their way to the thoracic duct, which drains not only the lymph areas of the intestinal tract but also those of the cervical areas. The bacilli then travel by way of the subclavian vein, through the right side of the heart, and the pulmonary artery to the capillary system of the lungs. While in these capillaries, they have every opportunity to reach the lymph channels, and are then likewise carried to the tracheo-bronchial lymph nodes at the hila. It is always to be remembered that tubercle bacilli, if they are to produce any effect, must penetrate the epithelial coverings and lodge in the tissues of the body. Tubercle bacilli are non-motile—they cannot propel themselves. They are ingested by wandering cells, such as polymorphonuclear leucocytes, and are carried into the lymphatic vessels. In these vessels their course, so long as they are moving, must always be centripetal, because there is not, under normal conditions, a centrifugal lymph circulation. Ultimately, after passage from lymph node to lymph node, they enter the venous system, either by way of the thoracic duct, or by shorter lymphatic trunks directly into the veins.

The first area, therefore, in which evidence of tuberculosis should be sought in the child is in the lymphoid tissue around the trachea and bronchi. The primary tubercle may, of course, and probably is, elsewhere, but such a primary lesion is too small to be demonstrated clinically. Krause has found clumps of bacilli in the tracheo-bronchial lymph nodes of a guinea pig within four hours after an injection of bacilli into a vein. It will be readily appreciated that these lymph nodes are infected for a considerable period of time before there are any clinical manifestations. It is only when the lymph nodes are overwhelmed by the bacilli that symptoms develop and the earliest form of tuberculosis in these cases is, in reality, a form of adenitis.

Symptoms. — Definite symptoms such as are seen in adults need not be expected. The earliest and most common symptom is fatigue. The child tires easily, or is disinclined to play, or may even be accused of being dull or lazy. Such a child, chronically tired or listless without apparent reason, should be suspected of having this form of tuberculosis-mediastinal or tracheo-bronchial adenitis. With this fatigue or listlessness there is usually *lack of appetite* and undernourishment, the latter being shown by loss of weight or failure to gain weight. Following these symptoms, nervous irritability and restlessness are frequently observed. Let it be noted that the healthy child is always willing to play, does not tire easily, has a good appetite, gains weight regularly, and is happy and contented. When these are absent the cause should be sought; and while not always due to tuberculosis, this disease should never be forgotten as a possible cause.

Physical Signs.—The physical signs may be vague or absent. Usually, there is some interscapular dullness, some also along the borders of the sternum, and usually some elevation of temperature. The X-ray, however, renders here one of its greatest services, in that it most clearly reveals the presence of enlarged mediastinal or tracheo-bronchial lymph glands. This enlargement is not in itself evidence of tuberculosis, because these glands may be enlarged from other infections—but in cases where there is the group of symptoms previously mentioned, with a background of exposure to infection, it is safe to treat the child at least as a suspect. The tuberculin test, on which so much reliance was formerly placed, cannot be considered as of real value—because it indicates merely infection, and will be positive in a large percentage of children; as infection is, in this coun-

try, almost universal at 15 years of age. In the very young it is of more value, but its value is appreciably less in children more than five or six years of age.

Extension of the Lesion.—As the lesion extends more glands become involved—and as there is a damming back of the lymph flow, glands along the bronchial tree become involved. In these cases there may be periodic cough—thought to be due to repeated colds. The cough is really due to pressure and irritation rather than to a true bronchitis, and is in this stage usually unproductive for this reason. Local sweating may be noted, as well as elevation of temperature after exertion or fatigue. These symptoms are the result of the reaction or sensitization of the tissues of the body to the toxic products of the tubercle bacillus. They usually disappear after a period of rest in bed.

While interscapular dullness may be found in these cases, and at times some dullness to the right of the sternum, there will not be detected dullness at the apices, nor adventitious sounds, because as yet the parenchyma proper is not involved.

The X-ray shadows will be irregular in outline in the areas of the hila, with others, linear in form extending upward and outwards into the lung substance, in the second and third interspaces. These are also, frequently, nodular.

The transition from this tuberculous tracheo-bronchial adenitis takes place in three ways:

(1) Direct extension outward into the pulmonary tissue more commonly in the middle or upper lobes on the right side, or the middle or upper part of the upper lobe on the left side. This is brought about by the lymph channels becoming blocked, producing stasis. Drainage being thus prevented, the bacilli may reach the parenchymatous tissue at any point from the hilum to the periphery of the lung.

(2) A second method of dissemination may be from a caseous focus in a lymph node. Bacilli being discharged into a vein may be carried to all parts of the lung tissue, giving rise to many scattered areas throughout the lung substance. This form presents the usual appearance of a generalized tuberculosis.

(3) By a third method bacilli may be aspired from a caseous node into a bronchus. A new area is thus infected, the type being that of a tuberculous pneumonia resulting from a massive infection and involving the whole area tributary to the bronchus.

Prognosis.—The prognosis of tuberculous tracheo-bronchial adenitis or hilum or mediastinal tuberculosis is good, provided suitable treatment is carried out for a sufficient length of time. What is a sufficient length of time is not always easy of determination; but it is safe to say that it has not been reached until the child *has become free from symptoms* and has attained *the normal weight for the height and age.*

In conclusion, let it be emphasized that early tuberculosis in children is not a disease of the parenchyma of the lung. Rales will not be heard. When this type of disease is found the case is already advanced—and the prognosis much more definitely unfavorable. Attention should be directed, not to the parenchyma but to the lymphatic system and, provided that other causes of similar symptoms and signs have been excluded, a diagnosis can safely be made when there is found:

(1) A history of contact.

(2) Undernourishment—shown by loss of weight or failure to gain weight.

(3) Diminished vitality—shown by fatigue.

(4) Signs of infiltration at the hilum.

(5) X-ray evidence of enlarged tracheo-bronchial glands.

(6) A positive tuberculin test.

So important is it to control a tuberculous infection in this early stage that it is advisable to institute appropriate treatment even when yet in doubt—because at this stage the prognosis is decidedly good. Delay permits the lesion to develop into the parenchymatous type of lesion with which the prognosis is anything but favorable.

The early diagnosis of tuberculosis in children promises even greater results than does the early diagnosis of this disease in adults. It is now universally recognized that in adults excellent results may be attained by treatment if the case is caught in the minimal stage. Much better results can be more surely predicated in tuberculosis in children if the case can be placed under treatment before the transition from the lymphatic lesion to the parenchymatous lesion has taken place.

Why is Posture so Important

By JESSIE H. BANCROFT, in "The Posture of School Children"

If one cares to sacrifice the pride of appearance, is there any other consideration that makes erect carriage of the body desirable or necessary? The answer is three-fold and most emphatic: Erect carriage of the body is necessary (1) for full vigor and health; (2) to prevent waste of energy in maintaining the upright position in any of the activities of life; and (3) with children, to admit of proper growth and development. To make plainer what is meant by each of these three points, it may be stated at once that only in the perfectly erect position of the body are the great organs of the trunk—heart, lungs, stomach, liver, kidneys, and other viscera that constitute the main working machinery of the body—in a position to perform their work to the best advantage. One may shift and change the position temporarily with a great deal of positive benefit; indeed, activity in work, gymnastic exercise, or sport, is necessary to health; but the habitual bad carriage of the body in walking, standing or sitting, or a faulty relation of its parts in habitual occupations (as in bending with a cramped chest over a desk or over sewing for many hours a day), may interfere seriously with the great functions of circulation, respiration, digestion, elimination, etc.

For these functions to work at such a disadvantage is, of itself, a waste of energy; and in addition to this, the expenditure of nervous and muscular effort required to maintain an incorrect standing position is greater than that necessary for a good position.

To children these general considerations apply as forcibly as to adults, but assume an especial importance; since the great physiological functions have in childhood not only to provide for the waste and repair of daily usage, but must furnish also material and energy for growth and development. Moreover—and this is of crucial importance—the posture of the spine, chest and shoulders, throughout the growing period, influences profoundly their ultimate contours and proportions. A well-developed chest, a back strong and normal in its growth, and shoulders and head well poised, are points of development that must be held of fundamental importance by every one concerned in the well-being of a little child.

International Council of Nurses' Congress at Helsingfors, July 20-25, 1925

President, Baroness S. Mannerheim, Kirurgiska Sjukhuset, Helsingfors, Finland; Hon. Secretary, Miss C. Reimann, Teachers' College, Columbia University, New York, U.S.A.; Hon. Treasurer, Miss M. Breay, 431 Oxford Street, London W., England.

Members: The American Nurses' Association; The Canadian Nurses' Association; The Danish Council of Nurses; The German Nurses' Association; The National Association of Italian Nurses; The National Council of Trained Nurses of Great Britain and Ireland; The National Federation of Belgian Nurses; The New Zealand Trained Nurses' Association; The Norwegian Nurses' Association; Nosokomos, Holland; The Nurses' Association of China; The Nurses' Association of Finland; The South African Trained Nurses' Association; The Trained Nurses' Association of India.

CONGRESS AT HELSINGFORS, JULY 20-25, 1925

The International Council of Nurses was founded in London, 1899. One of its achievements has been to provide opportunities for nurses from all parts of the world to meet in order to confer upon questions relating to their work. Thus Congresses have been held in Buffalo (U.S.A.), Berlin, Paris, London—and the last was in Cologne, Germany, 1912. The Congress in Helsingfors will therefore be the first large international gathering of nurses since the late war, which has had such an enormous influence on the development of nursing in almost all civilized countries.

Although the number of delegates for the Congress is limited, nurses from all countries and persons who are not nurses, but interested in nursing matters, are cordially invited to attend all but the strictly business meetings.

Arrangements and Accommodations for the Stay in Finland

Arrangements are being made for accommodating the visitors during the Congress in Helsingfors. In order that a sufficient number of rooms can be placed at the disposal of the participants, both in hotels and in private homes, it is important to know just how many there will be, and therefore it is urged upon those intending to go to write for reservations immediately. Arrangements must be made through the Committee on Arrangements, Kirurgiska Sjukhuset, Helsingfors, who ask to have all applications before April 1st. Please write a brief and clear application, indicating:

1—Name, address, and position of applicant.

2—Type of room desired in Helsingfors.

5—Probable date of arrival and length of stay.

A registration fee for the Congress of $1.25 (5s. 5d.) is payable on arrival, at which time the detailed program and badge will be available.

Before and after the Congress excursions will be arranged for, lasting 2, 3, 4, 5, 8 or 9 days. These trips—comprising old castles and beautiful sceneries, including Imatra, the most voluminous waterfall of Europe, and different institutions interesting to nurses—can be taken individually, or by groups. Travel in Finland is not expensive, and can be done at an average daily cost of M. 250,or about $6.00 (£1 5s. 6d.). Please note on the application blank if any of these excursions interest you and state the duration of days desired.

Preliminary Program

July 20th

Arrival at Helsingfors.

Morning and afternoon: Business meetings of officers and delegates. Registration. Musical Church Service.

Evening: Welcome to the delegates and guests. Addresses by prominent speakers on International movements in relation to nursing.

JULY 21ST

Morning and afternoon: General Sessions, especially concerned with the work of the International Council.

Evening: Introduction of new members.

JULY 22ND

Morning: General Sessions on "Administration and Teaching in Schools of Nursing."

Afternoon and evening: Excursions.

JULY 23RD

Morning: General Session on "Public Health Nursing."

Afternoon: General Session on "Special Fields of Nursing".

Evening: Open Meeting.

JULY 24TH

Morning: General Session on "Nursing Legislation".

Afternoon: Meeting of Officers and Delegates.

Evening: General Session on "Nursing Associations and Publications."

JULY 25TH

Morning: Boat ride.

Afternoon: Social gathering and farewell.

Although it is not yet possible to draw up the full schedule for the meetings, arrangements have already been made for a series of interesting addresses and discussions by leading authorities in nursing from many lands and also from representatives of Public Health and Social Welfare work. A number of Round Tables have been arranged in order to give an opportunity for small groups to discuss informally the most pressing problems coming up in relation to special fields of nursing. Arrangements will be made for special groups to meet for luncheons and dinners.

TRAVELLING AND ACCOMMODATIONS BEFORE AND AFTER THE CONGRESS

Bennett's Travel Bureau has been appointed Transportation Manager to the Congress and all bookings should be arranged through them. For details of schedules and rates apply to one of the following offices of Bennett's Travel Bureau, or their agents:

New York.....500 Fifth Avenue.
London.....66 Haymarket, S.W. 1.
Paris.....4 Rue Scribe.
Oslo (Christiania)..35 Karl Johansgate.
Copenhagen.....47 Raadhusplads.
Stockholm.....8 Vasagatan.
Berlin.....Interpreter's Office, Stettiner Bahnhof.
Amsterdam.....25 Leidschestraat.
Brussels.....V. Bull & Cie., Place Branckere.
Rome.....18 Piazza del Popolo.
Basel.....Reisebureau, Zwilchenbart, A. G., Centralbahnplatz 9.
Helsingfors.....A. B. Finland's Resebureau, Norra Esplanadgatan.

NOTES ON NORTHERN COUNTRIES OF EUROPE

Many going to the Congress will undoubtedly wish to spend a little time visiting the countries of Northern Europe. We are, therefore, giving a brief description of what there is to see in these countries, with suggestions for tours, that can be taken before or after the Congress.

FINLAND, BEAUTIFUL "LAND OF A THOUSAND LAKES"

Northern Europe has grown in popularity with the tourist ever since the World War. Finland is less known than the three neighboring Scandinavian countries, because of its situation away from the beaten track. He who visits Finland will, however, find the trip worth while, and be pleasantly surprised at the beauty and scenic charm of the country. He will find hills covered by deep pine or fir forests, here and there intersected by leafy groves, and all around large and small lakes, in the deep calm waters of which the surrounding trees are mirrored in the fairy-like light of the North.

With its forty thousand lakes and its numerous streams and rapids, Finland is a country unique in all the world. Finland is also a modern and progressive country, with good schools everywhere, even in the poor and sparsely populated Northern communities, with many power stations and plants at the numerous rapids and with its capital, Helsingfors, a beautifully laid-out city with a population of 200,000. Cleanliness is a characteristic of Finland. The Finlanders, whether of the old Finnish stock or of the Swedish stock living on the West coast, are

intelligent people who have brought forth scientists and artists of world renown.

The grandest scenery that Finland possesses is mainly located in the interior and in the Eastern part of the country. A circular tour to the spots best worth visiting can be made in about ten days.

Sweden, Land of Today and Yesterday

Sweden is the largest country in Scandinavia and nearest neighbor to Finland. Stockholm, the capital is one of the most beautiful cities in Northern Europe, a "Venice of the North" with palatial public and private buildings. Many interesting Royal Palaces are situated in the pretty surroundings and can be reached in half or whole day excursions. Uppsala, the ancient university city, is one hour by rail from Stockholm. Visby, romantic city of "Ruins and Roses," with memories of bygone days on the Isle of Gotland, is reached by steamer overnight. The Gota Canal is an interesting 2½-day water trip from Stockholm to Gothenburg, bringing us right across Sweden, passing interesting mediaeval castles and churches. Dalecarlia is the "heart of Sweden," one day by rail from Stockholm. Here the peasants can still be seen in their picturesque costumes.

Norway, Land of Fjords and Midnight Sun

No country in the world offers to the tourists such a varied combination of scenic beauty as Norway. The beautiful Hardangerfjord has its shores covered by luxuriant verdure and is dotted with picturesque red-painted farms, while snow-capped mountains tower above. The stern Sogne Fjord reaches with its arm the narrow Naero Fjord, 111 miles into the heart of the country. Perpendicular mountain walls soar up to 7,000 feet into the sky from all sides, and in between the mountains are deep gloomy canyons seldom touched by the rays of the sun. The Nord Fjord, according to Baedecker, is the finest combination of vast expanse of water with mighty mountains and glaciers. The Geiranger Fjord, only a quarter of a mile wide, has waterfalls everywhere tumbling down from heights of 2,000 feet or more. The Romsdals Fjord is surrounded by weird snow-capped peaks, such as the Witches' Pinnacles and Romsdalshorn, the Matterhorn of Norway. Lyngen Fjord in Northern Norway is one of the most superb color vistas imaginable, with its blue glaciers descending into purple shadowed gorges, mirrored in water clear as glass underneath the golden hue of the Midnight Sun. Finally, to watch from the North Cape, the "edge of the world," the phenomenon of the Midnight Sun and to see "Without one interval of darkness, the Past transfer itself into the Present and Yesterday become Today," is an unparalleled experience.

Denmark, Land of Progress

Although unlike the other countries, Denmark has with its pastoral beauty, its shady groves and smiling lakes a charm all its own, and not the least attraction is that it is unspoiled by tourists. He who wishes to take a rest from a hard year's work or a strenuous sightseeing trip, can do no better than spend a week or two in the country of Andersen's Fairy Tales, inland or at the shore. Of Denmark's three million inhabitants, almost one quarter live in Copenhagen, the capital. Copenhagen is the oldest and largest city in Scandinavia and also an important centre of learning, art and literature. Of special interest are the beautiful art collections and the modern hospitals of Copenhagen, whose splendid architecture has not yet been surpassed anywhere.

TRAVEL ROUTES TO HELSINGFORS

From Canada

One-class cabin steamers of the Canadian Pacific leave Montreal or Quebec every Friday for Liverpool, the crossing taking seven days. Through tickets to Helsingfors via Liverpool and Hull are issued at $30 increase over the ocean fare. There are also one-class cabin steamers of the White Star Line and large first and second class steamers of both lines from Canada to Great Britain and France, which can be used on the way to Helsingfors. The entire trip from Montreal or Quebec to Helsingfors takes from ten to fourteen days, depending on steamer and connections. Write to Bennett's Travel Bureau, Inc., 500 Fifth Avenue, New York, for further details regarding sailings and rates.

International Mercantile Marine Lines Sailings

S.S. "Megantic, "June 27th, minimum rate cabin class from Montreal to Helsingfors, via Liverpool, $175, plus $5 war tax.

S.S. "Regina," July 4th, rates the same as per "Megantic".

S.S. "Canada," July 11st, minimum cabin class rate from Montreal to Helsingfors, via Liverpool, $160, plus $5 war tax.

These three steamers carry one class cabin passengers only and the "Regina" is a new steamer, the largest ship sailing from Montreal.

The above rates through to Helsingfors include board and lodging in England while awaiting connecting steamer for Finland.

This company operates special College Tours in connection with the above sailings, passengers occupying improved third class space with special accommodation and catering. While these tours do not include Finland in the itinerary, passengers could book with the party to Liverpool and arrange their own forwarding to Helsingfors and back.

The rate of the ocean passage from Montreal to Liverpool on the "Megantic" and "Regina" is $85, plus $5 war tax, which as against the minimum cabin rates as quoted above represent a saving of approximately $60, based on the Liverpool rate. Folders descriptive of the College Tour may be obtained from the International Mercantile Marine Lines Agent, Toronto.

All passengers travelling from Canada must be in possession of passports, which are only obtainable through the Department of State, Ottawa. Application should be addressed to the Passport Officer, Department of State for External Affairs, Ottawa. Two unmounted photographs should accompany the application. The charge for each passport is $2.00. Canadian passports also require the visae of the Finnish Consul. This can be obtained in Toronto from Mr. A. Saarimaki, 119 Bay St., at a cost of $2.00.

Reservations may be made through any of the local agents or direct with the Company's office by depositing $30,00 for each cabin passenger and $20.00 for third class. Accommodation for the return journey may be reserved through any of the Company's offices or agents before the passenger sails for Europe.

N.B.—Nurses will please note that they must arrive in England not later than Tuesday, July 14th, otherwise they might miss the boat leaving Hull Wednesday, July 15th, which is the latest boat on which sailing may be made in time to arrive at Helsingfors for the opening of the Congress.

Booklets containing information relative to the Congress, travel routes to Helsingfors, and tours in Europe, may be obtained at the National Office, 609 Boyd Building, Winnipeg, Man.

International Society of Public Health Officers Formed

As the result of the recent interchange of public health officers under League of Nations auspices, the decision has been made to set up an international society open to all medical officers of health who are taking part in the various interchanges organized by the league. A provisional committee composed of members from Great Britain, Russia, France, Germany, Poland, Italy, and Ecuador is engaged in drawing up the constitution of the organization, which will have its headquarters at Geneva. Two hundred and forty persons from forty-three countries will be invited to become the society's original members. The organization will act as a medium of exchange information on all matters of public health. — "The Nation's Health," August, 1924.

*The Hospital in Relation to the Health Dept.

By HENRY A. ROWLAND, Phm.B.
Secretary, Department of Public Health, Toronto

MR. PRESIDENT, Ladies and Gentlemen,

In the first place, I wish to remind you that Public Health work, as an organized service, is of quite recent origin.

The Hospital, as such, however, has for centuries held an honored place in the heart of man.

As far back as history records, we find evidence that provision of a kind has been made for the care of the afflicted, while it is only during the past century that preventive measures have been attempted, and even today there are always groups of people who delight to talk about the good old days of long ago. These people are, very frequently, ably assisted in this by writers of fiction and by producers of moving pictures. There is, doubtless, an attraction in the apparently carefree life of the picturesque ladies and gallants of the past centuries. However, a moment's thought of the lack of what we consider every-day comforts, and of the general condition of the masses of the people of the old days, is surely evidence that the world progresses and that, with all our problems and difficulties, we can accept present conditions in a comparatively comfortable assurance that we are more fortunate that our ancestors and can look to the future for greater improvements in the lot of man.

While saying this and believing in the constant improvement of conditions, it is quite realized that changing conditions create new problems and demand different treatment.

We can look back to the small village with its general practitioner, who labored hard amongst its people and brought to them all the knowledge and skill then known. We may smile at the "Lady Bountiful" social worker of the past, but she fairly met the conditions as they were in her time.

The changes brought about by modern manufacturing and new commercial conditions have brought ever-increasing numbers to live in large and congested centres. Scientific discoveries have entirely altered the mode of living. Rapid transportation, electricity, telegraphy, telephones and so on, have affected the lives and the living conditions of everyone.

During this same period, medicine also has made progress. With increasing knowledge, new machinery and new methods have been developed so that the masses of the people have also been benefitted thereby. With the work of the immortal Pasteur over half a century ago, medical science made great strides in knowledge of the cause of disease, and with this the possibilities of prevention came to the front. As a result of the marvellous discoveries, during and since Pasteur's time, most communities have now permanently organized health departments, whose duty it is to apply this knowledge of preventive medicine for the benefit of the community in co-operation and close alliance with the hospitals and other similar institutions, many of which have already been long established.

I presume that the reason for asking me to present this paper was that it was thought that my position has brought me into contact with both the Health Department and most types of hospitals, and while I regret my inability to do justice to this subject, I assure you I keenly appreciate the honor you have done me by placing my name on the programme.

As I understand it, the Health Department and the Hospital are one, in the same way as all medicine, with

its specialties, is one. The Health Department exists to carry on one branch, that of preventive medicine, in a community sense, but certainly not in any isolated way.

My remarks, therefore, will be based on this assumption and of the impressions I have as to how the Hospital, as the senior branch, can aid the junior branch in its work of safeguarding the health and the lives of the citizens in its community. In support of this, I will give a very short outline of certain phases of our public health work in Toronto, which will show the very close relationship existing in that city between the various city hospitals and the Health Department. The communicable diseases are already a problem that is of interest to both Hospital and Health Department.

In Toronto, the Isolation Hospital is operated under and by authority of the Local Board of Health, and in consequence is administered by the Department of Public Health, as provided for in the Public Health Act of the Province of Ontario. If the bed capacity is large enough to make this method administratively economical, as it is in Toronto, then we believe it is the better plan, otherwise it might seem more reasonable to have an isolation wing as part of a general hospital.

In any case, the proper hospitalization of communicable diseases is necessary, both in the interest of patients who cannot be properly cared for at home, as well as to prevent the spread of infection where isolation in the house cannot be definitely maintained.

Unfortunately, sickness of all kinds and poverty very often go hand in hand. It is impossible to do proper health work in the home that has not a sufficient income to meet its reasonable needs. Furthermore, this lack of income frequently results from sickness. It must be apparent then that the health worker, whose primary duty is to apply the knowledge of preventive medicine, is also definitely interested in the proper medical care of the sick.

To my mind, an excellent way of providing for the hospital care of the indigent sick is as we have it in Toronto. Patients requiring in-patient treatment are admitted to the wards of the various hospitals and sanatoria. The city pays the per capita diem rate of $1.50, which rate is set by the Provincial Government, and is applicable for all indigent patients who can prove residence in the municipality. The responsibility for deciding as to the patient's eligibility for treatment at Toronto's expense is left to the City Relief Officer, who examines him as to financial conditions and residence. Those who can be cared for in the out-patient department of the hospitals are given treatment there, the city paying 32c for each visit or treatment. This is one point at which we feel the city's interests should be carefully safeguarded, as there are doubtless patients attending out-patient clinics in Toronto, as in many other cities, who are able to pay and should go to a private physician. Whenever there is reason to question their eligibility for free treatment, a report from the district Public Health Nurse can speedily settle the point.

During the year 1923, the city of Toronto paid to the hospitals and sanatoria the sum of $720,000 for maintenance of indigent in-patients, on the $1.50 per diem basis, as well as the sum of $55,000 on account of indigent out-patient treatment. Many of these cases were sent to the hospital on the recommendation of a Public Health Nurse. This is another demonstration of the close co-operation between Hospital and Health Department.

However, I believe that while the Health Department is, for the reasons given, interested in the fact that the sick be cared for, it should not be a function of that department. The department may be forced into

treatment work for various reasons, but when it is, it is getting out of its real field and expending appropriations that should be otherwise used. The actual medical and nursing care of the sick is, of course, a long way from the finished treatment of the patient. This fact has been recognized and an effort made to deal with it through the Hospital Social Service Departments.

In Toronto, the Toronto General Hospital has its own efficient Social Service Department, and in this way, by co-operating with the Health Department, it relieves the city of the cost of this service. For the other thirteen hospitals and the five sanatoria, to which Toronto's patients are admitted, the Public Health Department provides the service as part of the public health nurses' programme. This is carried out by placing one or more public health nurses in each hospital and using the general field staff to do the home visiting, reporting, etc. Thus, the actual hospital group is really multiplied to the number of field workers for home contacts, and the nurse who already knows the home and is known to the people is still used in that home. The results achieved in Toronto through this method of follow-up amply justify the work and expense it entails. This method has also meant a very satisfactory linking up of two services (a good piece of team work), both the Health Department and the Hospital helping to solve the problem of the home. In addition, the hospitals are teaching centres, and as such, affect the work of the next generation by means of their influence on their graduates, many of whom finally attach themselves to Public Health Organizations.

There are certain other definite public health problems, that affect to a great extent the whole community, which are largely institutional or hospital ones, such as—

Tuberculosis Cases—These make great demands upon Hospitals and Sanatoria, the institution being an essential link in the chain of care and prevention of this disease.

Mental Cases—Which are so closely interwoven with all health and social problems, must be studied and in many cases cared for in the hospital.

At the present time, under the Department of Public Health in Toronto, there is a staff of Mental Hygiene Workers, under the direction of a Psychiatrist. The staff at present consists, besides the director, of two nurses, with special psychiatric training, two psychologists, a psychiatric social service worker and a stenographer.

Realizing that the most constructive work can be done in this field in the education and training of the feeble-minded child, the Division of Mental Hygiene specialized on school survey work, and the follow-up of the graduates from the system of auxiliary classes that are maintained by the Board of Education, with whom we work in very close co-operation. Through the activities of this staff, fifty auxiliary classes have been inaugurated, with two trade schools for adolescents, one for boys and one for girls, and while it is felt that this number is not sufficient for a city the size of Toronto, the opening of additional classes is retarded owing to the over-crowded condition of our schools. Many of the cases of mental disease that are encountered by the public health nurses in their districts are also handled through this division, which of necessity works in close co-operation with the psychiatric clinics in general hospitals, with the psychiatric division of the Juvenile Court, and in an advisory capacity to such organizations as the Big Brother and Big Sister Branches. It is hoped that the follow-up system which is now being developed will, even in a comparatively short time, inhibit many cases that would otherwise become delinquents.

Venereal Disease Cases—The treat-

ment of venereal disease is carried on in Toronto hospitals as part of a provincial scheme for the control of these diseases. The war, which brought to public attention in Canada the fact that these diseases constitute a serious national menace, also furnished sufficient public opinion to make possible the passage of laws dealing with their control and the granting of money for their treatment.

In 1918, the Venereal Disease Prevention Act of Ontario was passed. Under the provisions of this Act, all hospitals receiving government aid were required to provide treatment for these diseases.

In 1920, the Federal Government of Canada granted $200,000 for the work of Venereal Disease Control, the money being distributed between the various provinces on a per capita basis, one condition being that the province receiving its share of this grant must also provide an equal amount. The Province of Ontario has had annually since 1920 the sum of $114,000 to help carry on this work.

On behalf of the Federal Government the Provincial Board of Health makes all arrangements with the various hospitals and other institutions when establishing the clinics. The Provincial Government allows the hospital the sum of $1,000 towards the initial cost of clinic equipment, $500 annually towards the salary of a physician and a similar amount annually towards the salary of a social service nurse, as well as 50c per day for each in-patient and 50c for each treatment given in the out-patient clinics. The records are standard for all clinics and are also supplied free by the Provincial Board of Health. In addition to these payments, the city of Toronto pays the hospitals the same rate as is paid for other indigent patients for all Toronto V.D. cases given treatment in both in-patient and out-patient departments of the hospital. This same rule applies to all other municipalities.

There are, in Toronto, under the government scheme, six clinics, located in as many hospitals. By an arrangement made between the Provincial and Local Board of Health and the Hospitals, the clinics are held as far as possible at different hours. In this way, it is possible to secure treatment for a venereal disease case at any hour of any day of the week, except Saturday and Sunday. During 1923, 1367 new patients were admitted to these clinics and 33,584 treatments were given. During this same period the social service nurses in Venereal Disease Clinics in Toronto made 3,405 visits to the homes of their patients. During the same period 657 persons, the contacts and alleged sources of infection for veneral disease cases were examined, with the result that 164 of these were found to have syphilis and 44 to have gonorrhoea.

The Provincial Board requires that each Venereal Disease Clinic, in order to be eligible for government aid, must employ a full-time social service worker, who shall be a graduate nurse. In Toronto, the nurses in all the hospitals, except one, have been appointed and are paid by the City Department of Health. The $500 paid by the government to the hospital is forwarded from the hospital to the Department of Public Health and the amount is credited by the Health Department to the cost of maintaining a nurse at the hospital in connection with this work.

There are numerous other health services furnishing opportunities for treatment and cure, which are made possible only by means of the close co-operation of the hospital and health department. In other words, the hospital, by caring for the sick, permits the re-adjustment of the home by health and social agencies, and also is a factor in the prevention of the spread of infection through hospitalization of cases. The

(Continued on page 97)

Sight Saving Classes in Toronto

By BARBARA A. ROSS, Reg. N.,
Supervisor of School Nursing, Degartment of Public Health, Toronto.

WITHIN recent years, increasing interest has been shown in the welfare of the handicapped child. As a result, several kinds of auxiliary classes have been established to meet the special educational needs of these children. One type of auxiliary class which is comparatively new is the one established for the benefit of children handicapped by sub-normal vision, who are unable to benefit from the instruction of the ordinary class room but are not suitable pupils for the Institute for the Blind. These classes are called Myopic Classes, Conservation of Vision Classes, or Sight Saving Classes.

The movement for better care and training of children with defective vision began in England following the meeting of the International Congress of School Hygiene, held in London in 1907. To Dr. N. Bishop Harman, the founder of Myopic Classes in London, is due largely the success of this progressive step in elementary education. The success of this project in England led to the establishment of sight saving classes in the United States—in Boston and Cleveland in 1913. Many other cities in that country have since followed their example. There are now over forty of these classes in operation in New York City.

The first sight saving class in Canada was opened in Halifax in 1917, soon after the explosion in Halifax harbor.

In Ontario, the Auxiliary Classes Act, passed in April, 1914, provides for the establishment of Myopic Classes or Special Classes for children whose sight prevents them making satisfactory progress even when provided with proper glasses and placed in front seats, or whose sight would be further impaired by using the ordinary text-books and other means of instruction.

In Toronto, many school teachers, the members of the school medical staff and some leading oculists, especially those connected with the clinics of the Hospital for Sick Children, believed that there was an urgent need for such classes in our schools. A committee was formed under the auspices of the Institute for the Blind to gather data, indicative of the extent of the problem of defective vision in our schools. A survey of the Public Schools was carried on in 1920 in co-operation with the Department of Public Health and the Hospital for Sick Children, utilizing the existing hospital school and district records.

According to the medical advisers consulted by the Survey Committee, children with only one-third or less of normal sight would certainly fall in the class of those with defective sight requiring special classes. Thus, only those children who tested 20/60 or less by the Snellen Test were considered in the survey. In ordinary English, this means that the smallest type that any of the children considered could read at a distance of twenty feet was nearly an inch high, whereas, at this distance, a normal child can read type about one-third that size.

Four hundred and ten cases were recorded, and of this number one hundred and sixty-five had received treatment which had proved ineffective. It was reasonably certain that no treatment would make these pupils suitable for the ordinary class. The remainder had not yet received treatment, but even after treatment many would doubtless require special instruction.

The presentation of these findings to the Board of Education resulted

in the establishment of Toronto's first sight saving class in Orde Street Model School in March, 1921. Two other classes have since been opened —in Duke of Connaught School, March, 1923, and in Brock Street School in September, 1923.

With the limited accommodation available, prospective pupils for those special classes are carefully studied before admission. Probable cases are brought to the attention of the school medical officer in the routine physical examination, and in special examinations—when the school nurse thinks that special treatment may be necessary. The nurses may come across these pupils in the course of a class-room inspection or they may be referred to the nurse by the teacher who has noticed that Jimmie or Annie isn't getting along well. The child may come to the nurse complaining of sore eyes or headaches or inability to see the blackboard. Some cases are referred by private physicians and hospital clinics.

All these pupils are examined by the school medical officer, who recommends for further examination those whom he considers may be suitable cases for the special classes. The eye specialist attached to the Department of Public Health makes the final examination and decides as to admission. In addition to examining for admission he examines each pupil once a month, records his findings and advises the teacher as to the amount of reading and writing to be done by each pupil.

As the aim of the sight saving classes is to minimize eye-strain, the equipment and method of class-room instruction are adapted as far as possible to this end. A large, light, airy room with north or north-west exposure is most desirable. If that is not available, as it is not in one of our schools, blinds at the tops of the windows, and at top or bottom of the lower sash are required to diffuse the sunlight (to be adjusted to shut out as little light as possible). For dark days there is indirect electric lighting. All surfaces in the class-rooms, such as walls, desks and blackboards, have a dull finish to lessen the glare. The walls are buff in color, the desks are moveable and adjustable, with sloping tops which prevent the children from sitting in a stooping position. Ample blackboard space is provided for use of the pupils to encourage free-arm movement and large characters in writing and drawing. Other equipment consists of a table for manual work, a series of twenty-four point type texts for supplementary reading, a type-writer, a type-writer stand, piano, dull, buff-colored paper with green lines for seat-work, reed for basketry, outline maps and reading charts for junior pupils.

The lesson periods are short. Games, songs, folk-dancing and handiwork are enjoyed as relief from routine work which implies eye-strain. The pupils learn to do weaving and basketry by touch. Sewing is not allowed, but knitting is permitted if done automatically. The senior pupils are taught to use the typewriter.

Oral instruction and recitation of senior pupils are taken in common with the normal children. They are delighted to measure up with the pupils of the regular class. Besides promoting a more normal life, this mingling with others stimulates competition with those who will later be their competitors in business life. All the pupils of the sight saving class mingle with the rest of the school at recess without restriction.

The care of the eyes at home and at school is emphasized, and home habits in this respect are checked up as far as possible.

Very much more depends on the teacher in the sight saving class than on the teacher in an ordinary grade, as she is cut off from the book method of modern teaching. Each pupil requires individual attention. Several grades may be represented in the one

class. It is therefore quite easy to understand that fifteen pupils is considered the maximum assigned to one teacher.

One of the contributing factors to the success of those classes is their happy atmosphere. It is a pleasure to see the delight shown by the pupils in their work. They are quite free from that regrettable sense of inferiority which is often the affliction of the handicapped. Whatever unhappy experience they had in the ordinary class-room, where failure to keep up with the others was usually their lot, they are now happy and contented, as under wise and sympathetic guidance they are led little by little to conquer what had been to them insurmountable barriers to education.

The sight saving classes in Toronto, as elsewhere, have already proved of great value. Since the opening of the first class in 1921, nine pupils have been discharged with vision so improved that with care they are able to carry on in the ordinary class-room. We should explain that such cases are not considered ideal for these classes, but were admitted when the work first began in our schools. The ideal cases are those whose vision will never improve and who will require to remain in the sight saving class during their entire public school career. In these latter cases, it is encouraging to note the progress made. Many of these pupils on admission to the class were behind the usual grade for their age, and most of them in a short time more than made up for time lost. Two have passed the high school entrance examination, which would doubtless have been an impossibility if they had remained in the regular class-room.

Up to date, no further provision for this type of child has been made in Toronto. There are no sight saving classes in the high schools as yet. We hope when the need arises to receive assistance from the Technical School as to vocational instruction. In order that these children do not lose the benefit already received from the sight saving class and that they may become useful citizens instead of burdens on the State, it seems very necessary to secure for them further vocational guidance and supervision.

Resume of Address by Dr. D. S. McNab, Calgary, to Graduating Class, Holy Cross Hospital, Calgary, June, 1924

Very great changes have taken place in the methods of caring for the sick. Formerly these were of a most haphazard and inefficient kind, but the development of modern education demanded highly skilled and scientific physicians and nurses.

The history of nursing makes romantic reading. Turning over the pages one sees the daughters of Aesculapius, the lay sisters of the Crusaders, St. Frances and St. Hedwig—the last two performing the most menial tasks of the probationary nurse.

In 1546 St. Bartholomew's was made over to the Mayor and Council of the City of London, who established the nursing staff of those days. It is revolting to think that many of the members of what is now one of the noblest of professions, demanding above all elevated aspirations and high ideals, were taken from the lowest grades of society. In 1829 the first attempt in England was made to train and send out nurses to care for the sick in their homes. In 1836 Kaiserwerth "Motherhouse," in Germany, formed the starting ground for the modern training school. The modern conception of a nurse, however, came largely through the influence of the famous Florence Nightingale, who was well born,

highly educated, beautiful of form, but even more beautiful in nobility of mind, and much in advance of the prevailing ideas of her age. In 1851 she visited Kaiserwerth and other places to study the nursing system of continental hospitals. In 1854 the Crimean War gave her an opportunity to put into practise and show the advantages of her humane ideas. From her time, and largely as a result of the noble sacrifice of her own life to nursing, the calling has made immense strides until it has reached the position of being one of the most essential and respected of professions.

The success of a nurse depends not only on what she knows, but on what she is. The performance of her nursing duties is but a small part of her training, which includes the development of right character, attitude of mind, habits of life. It is not enough to become an average nurse. To be successful the nurse must not seek merely selfish ends—preferment, honor, power: her prime duty is to develop the ability to solve her problems, to acquire knowledge and character. Study is important; diligence and sincerity are indispensable. She must cultivate personality in order to exercise helpful influence over the sick. A firm will must also be hers so that she may carry out the purposes she knows to be right. She should be adaptable in order to overcome adverse circumstances. Resource will enable her to give the full benefit of her training to her patients.

She must be industrious and willing to pursue her calling even against her inclinations: i.e., she must be willing to do her duty in conditions which are unpleasing. She must learn to control her temper or much of her good work on the body will be undone by the effect of anger on the mind of her patient. She must learn to so influence the patient that by skilful tact she may have her own way even when their inclinations are opposed to her. She must be loyal to her training school and the doctor. Above all, she must pursue a policy of generous loyalty to the welfare of the patient, respect his rights, his private affairs, and do all she can to promote his recovery.

Finally, she must be tactful: know what to do and what to leave to others. Her resourcefulness will enable her to make the necessary modifications to adjust herself to her many and ever-changing environment. She must be prepared for the inevitable withdrawal of intimacy as the critical period passes and the family returns to its normal habits of life.

The many irregularities in general living conditions to which the nurse is forced to adapt herself emphasizes the attention she must pay to her health, and she must remember not to overlook such things as rest, exercise, sunshine, regular food, and fresh air in order that her body may maintain its normal standard and be able to resist not only disease, but also the depressing conditions of the sick room.

"In conclusion," Dr. McNab said, "I beg to call your attention to the institution from which you are graduating—an hospital standing at the top of the class in the group of hospitals to which it belongs. Be loyal to it; also to the sisters who have instructed you—devoted, capable, earnest, conscientious women, who have worked hard to instil in you the qualities mentioned. We knew you as probationers, entering the hospital unfamiliar with the ways of the institution, yet full of willingness and determination. We have watched you as you passed through the various years of work and courses of study; have watched your characters unfold, and now in the full bloom extend to you our hopes, our best wishes, our most sincere congratulations, and the more material sheepskins."

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
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Immunity and Immuno-Therapy

By W. MAGNER

PART II.

THE natural defensive forces of the body having been reviewed, it remains to describe the course of events following upon an overthrow of these defences, or in other words, the occurrence of an actual infection. Such an event implies that the bodily forces have been temporarily vanquished, but, unless the victim's resisting power is abnormally low, or unless the bacteria gain access in overwhelming numbers, the fight is only in its preliminary stages. During the early days of the infection the leucocytes and antibacterial substances normally present in the blood are unable to cope with the bacteria, which multiply and produce abundant toxins that poison the patient's tissues and produce various symptoms, such as headache, pyrexia, malaise, and perhaps certain localizing symptoms due to involvement of some organ, such as the kidney, liver or gastro-intestinal tract. In a favorable case, however, from the very onset of the disease the patient's tissues respond to the emergency by mobilizing their resources. More and more leucocytes of the type best fitted to cope with the invading bacteria are formed in the bone marrow and poured into the blood stream; greater and greater quantities of antisubstances are produced, and finally the micro-organisms are destroyed and recovery ensues. Following upon this victory the number of leucocytes in the blood rapidly returns to normal, but the antibodies usually persist for long periods, during which the patient is immune or resistant to fresh attacks from that particular bacterium. A response of this type, characterized by a rapid and abundant formation of antisubstances which persist in the blood long after recovery, is constant in the case of many of the commoner acute infectious diseases. In others, however, such in influenza and lobar pneumonia, antisubstances, if formed rapidly, disappear, and as a result recovery is not associated with the development of immunity. Actually, individuals who have been through an attack of pneumonia or influenza appear to be less resistant than a normal individual.

Leucocyte Count

A study of immunity reactions, or in other words, the changes which occur in the blood during the course of an infection, has led to the development of many tests which are valuable aids in diagnosis. Thus an enumeration of the number of leucocytes in the blood is, as every nurse knows, a common procedure. It serves to determine the presence or absence of an inflammatory focus in the body, as the development of such foci is almost invariably associated with a very great increase in the number of circulating leucocytes.

Widal Reaction

Again infection with the typhoid bacillus leads to the appearance in the blood of certain antibodies known as "Agglutinins," because they possess the power of agglutinating the bacilli or causing them to come together in clusters. The "Widal Reaction" or "Agglutination Reaction," which is so commonly used in the investigation of a suspected case of typhoid fever depends upon the presence of these agglutinins. In carrying out the reaction the patient's serum is added to a suspension of typhoid bacilli in saline solution and the mixture observed either with the microscope or the naked eye. If the bacilli cease moving about in the fluid and finally cluster together, we have demonstrated the presence of specific antibodies for the typhoid bacillus, and are justified in assuming that the patient is suffering from typhoid infection, or has suffered from such an infection at some previous date.

Pneumococcus Typing

In cases of lobar pneumonia it is often of importance to determine the type of pneumococcus which is responsible. Here also we apply our knowledge of immunity reactions, but in a somewhat different fashion. Pneumococci are classified as belonging to Type I., Type II., Type III., or Group IV., the latter comprising several closely allied strains, and in the laboratory is kept a supply of antiserum for each of the first three types. This antiserum is prepared by inoculating horses or other animals with the type in question, and, like typhoid antiserum, has the power of agglutinating the particular strain of pneumococci of other types. In carrying out the test the procedure is to isolate the organism from the patient's blood or sputum, suspend it in saline solution and determine which antiserum causes its agglutination. If it is not affected by antisera for either of the three definite types, it is classified as belonging to Group IV.

Tests similar to those described, in as much as they depend upon the development of antisubstances in the animal body following upon natural or artificially produced infections, may be employed in the diagnosis of various other bacterial diseases, such as tuberculosis, gonorrhoea, bacilliary dysentery and Malta fever.

The study of immunity reaction has not only provided us with tests which have simplified the diagnosis of many bacterial infections, but it has also led to some of the most brilliant and epoch-making advances in the prevention and treatment of human disease.

(To be concluded. Part I. appeared in the December number of "The Canadian Nurse.")

CORRECTION

The table of statistics of Red Cross Home Nursing classes in Canada, as published on page 745 of the December number of "The Canadian Nurse," should read:—

Canadian Red Cross Home Nursing Classes—January to June, 1924

Province	Classes in operation June 30-'24	Classes completed Jan.-June	No. of pupils in completed classes Jan.-June *
British Columbia	0	14	260
Alberta	2	1	26
Saskatchewan	9	0	0
Manitoba	0	3	68
Ontario	24	62	709
New Brunswick	0	1	4
Prince Edward Island	0	2	26
Total	35	83	1,093

R. E. HAMILTON, R.N.

*75% Attendance.

Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section.
Miss EDITH RAYBIDE, General Hospital, Hamilton, Ont.

The Training of Nurses

(EDITOR'S NOTE:—*The following article written by Herbert L. Eason, C.B., C.M.G., M.D., M.S., Superintendent, Guy's Hospital, London, was published in* THE WORLD'S HEALTH, *August, 1924. This article is a criticism of the Report on Nursing and Nursing Education in the United States, as prepared by the Committee appointed by the Rockefeller Foundation for the study of Nursing Education.*

We are pleased to publish with Dr. Eason's article a letter written by Miss Jean E. Browne, President, Canadian Nurses' Association, to the Editor, THE WORLD'S HEALTH. *Miss Browne's letter was published in the November number of* THE WORLD'S HEALTH.")

THERE is something in the dry yet intoxicating atmosphere, both physical and mental, of the United States that stimulates the reforming spirit, which occupies itself not only with the States themselves but with other countries less favored both in climate and social conditions. With the aid of the vast sums of money provided by the Rockefeller Trust, its directors are able not only to carry on investigations and crusades in the New World, hitherto deemed impossible in the more lethargic Old World, but actually to extend their activities to all the quarters of the globe in the hope of making the whole universe a place fit for Americans to live in and to be satisfied with. Hence the Rockefeller Foundation is familiar to the well-informed of all countries as a patron of research, an organiser of investigations, and a munificent benefactor to those who may persuade the almoners of this great trust that their work is valuable.

For this reason any volume that appears before the world with the imprimatur of the Rockefeller Foundation is bound to be read and received with serious attention and anxious consideration. The report under review, dealing with the problem long familiar to the United States and England, and of pressing importance in other countries where the nursing of the sick is not yet highly organized, should be and will be read by everyone, in every country, who is interested in the development and progress of the profession of nursing.

But a word of warning must be uttered lest the recommendations of the Rockefeller Committee be taken as applicable to every hospital in every country, however primitive. The old parable as to the putting of new wine into old bottles is still apt, and there is a very great danger that the new wine of the Rockefeller Foundation may burst the bottles in many a country of Eastern or even Western Europe, if poured in too rapidly. With this warning let us review the main conclusions arrived at by the Committee.

PRELIMINARY EDUCATION

The Committee think it should be laid down as a general principle that every training school should require that all applicants for admission should have taken a full high school course of training; and it distresses them to note that there has been a striking decrease between 1914 and 1918 in the number of training schools in the United States requiring the full high school course before entrance. The percentage fell from 40.6 in 1911, to 28.1 in 1918.

It may be said at once that even in England it is impracticable to *require* a full high school course from every applicant. To do so would merely result in an insufficient supply of nurses. As nursing service in hospitals in England is still voluntary, one must take the best applicants one can get, and it is difficult to see how one is to obtain a higher standard of preliminary education except by the co-operation of high school head

mistresses, and by propaganda in schools in support of nursing as a profession. And head mistresses rightly say that it is difficult for them to help the hospitals to any appreciable extent as long as there is any considerable interval between the age for leaving school and the age for entering a hospital; for in this interval the girls pass out of the sphere of influence of the head mistress and take some other occupation or profession.

HOSPITAL TRAINING

The Committee is strongly opposed to the existing "apprenticeship" system of training nurses. It is stated that:

"Gradually it has become apparent that the old system is a slow and cumbrous method of education; that it often has not even the virtues of true apprenticeship wherein pupils work directly under the eye of a master. For in the hospital ward the immediate superior of the new student is the head nurse, responsible for the management of the ward unit, large or small, according to circumstances. Her duties are principally executive; as a teacher she is rarely equipped. With the best teaching equipment, she must in any case, after satisfying the imperative claims of ward management, have but the scantiest margin of time or attention available for the students. Often, indeed, she is herself a student learning administration, the practical running of a ward with its countless details as to supplies, assignment of nurses, household management, etc."

The remedy suggested is that the hospitals to which training schools are attached should be staffed almost entirely by trained women, and that the probationer nurses should enter the wards on much the same footing as medical students; to be taught, but not to do the work. And the trained nurses are to be relieved of most of their routine work by the introduction of a lower grade of nurse, or nursing worker, a child of Gibeon, who shall hew the wood and draw the water while the trained nurse does the really useful things.

The main objection of the Committee to the present system of nursing training is that it involves routine duties, and these are abhorrent to the Committee. They state:

"The probationers' time is as plainly misused as in excessive ward work when they spend weeks in making surgical dressings for the hospital which they could learn to make in a week, or waste months in the diet kitchen preparing salads for private patients, cooking in quantity for the wards, or cleaning vegetables. Such time is worse than wasted, for the unreasonableness and monotony of such assignments naturally tend to chill the beginner's enthusiasm and responsiveness to the first flush of interest in her new career."

One may say at once that cleaning vegetables and cooking for the wards is *not* done by the nurses in English hospitals, but by the kitchen or domestic staff, but there are many routine duties which must be carried out daily by nurses both while in training and in private practice; and routine is not only a valuable factor in education, but a most valuable assistance to intellectual development. One must be always thinking. In this connection it may be permissible to quote from Professor A. N. Whitehead, one of the most distinguished mathematicians and philosophers in England, who is shortly going to the University of Harvard as Professor of Philosophy:

"It is a profoundly erroneous truism, repeated by all copy books and by eminent people when they are making speeches, that we should cultivate the habit of thinking of what we are doing. The precise opposite is the case. Civilization advances by extending the number of important operations which we can perform without thinking of them. Operations of thought are like cavalry charges in a battle—they are strictly limited in number—they require fresh horses, and must only be made at decisive moments."

This is an admirable apology for routine as an educational factor.

Operations and services performed day after day throughout a period of three years become bone of one's bone, automatic but thoroughly accurate, reliable and unforgettable. To keep nurses learning new things every day without considerable intervals of routine will lead either to superficiality or mental breakdown.

Length of Curriculum

The curriculum is to be intensified and shortened by the reduction of the present three years to two. The Committee states:

"In our opinion the reduction of the present three-years' course is of the first importance, both in order to aid in meeting the increased demands for nursing service of all kinds in all parts of the country, and to aid in recruiting students who may well hesitate to devote three years to a training to which they may be willing and able to give a shorter period of time. The three-years' course not only should be radically reduced by about one-fourth, but can, in our opinion, be so reduced to the advantage of training."

The curriculum suggested is given below:—

Curriculum

Proposal for Preliminary Terms (15 weeks). SUBJECTS	Total hrs.	Hours per week: Lecture	Laboratory
Chemistry	60	2	2
Anatomy and Physiology	90	2	4
Bacteriology	45	1	2
Elementary Nursing (including Bandaging and Hospital Housekeeping) (1)	90	2	4
Personal Hygiene	15	1	--
Dietetics and Cookery	60	2	2
Introduction to Social Aspects of Disease	15	1	--
Drugs and Solutions	15	--	1
	390	11	15

Proposal for the Division of Service.	Months
Medical, including Medical Wards, Communicable Diseases, Diet Kitchen (2)	6
Mental and Nervous	2
Surgical, including Surgical, Gynecological and Orthopaedic Wards, Operating Room or Accident Room (2)	6
Obstetrical	3
Pediatric (2)	2
Dispensary, including Medical Clinics, Surgical Clinics, Children's Clinics	3
Vacation	2

Proposal for Theoretical Instruction.	Hours
Nursing in Medical Diseases	45
Elementary Pathology	15
Materia Medica	30
Diet in Disease	15
Massage	15
Nursing in Surgical Diseases, including Gynecology	--
Operating Room Technique, Orthopaedic Nursing	45
Nursing in special Diseases, Eye, Ear, Nose, Throat and Skin	15
Obstetrical Nursing	30
Nursing in Diseases of Infants and Children	30
Nursing in Communicable Diseases including Venereal, Tuberculosis	45
Nursing in Mental and Nervous Diseases	45
Applied Medicine and Public Health	30
Elementary Psychology	30
Social Aspects of Disease (supplementing preliminary course)	15
History of Nursing, including Ethics, Professional Problems	45
	450

Total: 2 years, 15 weeks.

(1) In addition to instruction in the preliminary term, additional hours in nursing procedures are planned for the summer term.

(2) In addition see under Dispensary.

On reading this through, I feel like the Harvard student, who, after one of his courses of intensive study, was asked what he thought about it: "Well, Doc" he said, "I feel just numb."

As a curriculum for a woman doctor it is inadequate; for a nurse it is excessive and superfluous. The Committee appears to look upon a nurse as a person to be trained to become a sort of doctor's assistant. This is not her function. Her duty is to carry out accurately the instructions of the doctor as to the nursing of the patient; it is not her duty to assist in treating the patient. The argument that she should be in a position to understand all that the doctor is doing and ordering is fallacious. To do so she would have to have a full medical education, and become a doctor herself.

A curriculum such as that outlined, though it looks well on paper, will fail in practice. What the nurse will be taught will be beyond her powers to absorb in the time allotted, and she will only get a dangerous smattering of many subjects which she cannot thoroughly grasp. It is far better that she should accept a more modest programme and learn it thoroughly.

I have read this important volume carefully through from cover to cover, but I must say that I am not as yet converted to the view that the apprenticeship system of training nurses is a failure. I have often taken American visitors over my hospital and answered their enquiries. I am always amazed at the apparent hopelessness of our methods as seen by their eyes, and at their despairing admission that after all we turn out in England a nurse who is second to none. As one responsible to some extent for the training of nurses in my own hospital I feel rather like the artist in Don Quixote who, being asked what he was painting, answered modestly: "That is as it may turn out." We do our best according to our lights, and must be judged by the result. And I do not think that everything lies in intensive courses and "quizz" classes.

I feel that in our hospitals we may to some extent resemble Oxford, as viewed by Professor Stephen Leacock:

"Oxford is a noble University. It has a great past. It is at present the greatest university in the world, and it is quite possible that it has a great future. Oxford trains scholars of the real type better than any other place in the world. Its methods are antiquated. It despises science. Its lectures are rotten. It has professors who never teach, and students who never learn. It has no order, no arrangement, no system. Its curriculum is unintelligible. It has no president. It has no state legislature to tell it how to teach, and yet—it gets there. Whether we like it or not, Oxford gives something to its students, a life and mode of thought, which in America as yet we can emulate but not equal."

We in England are conservative, bound to some extent by tradition, influenced by atmosphere and antiquity, self-depreciatory and yet hard to move.

Are we right or are we wrong in our methods? I feel that the result, and not the theoretical curriculum, is the criterion by which we should be judged.

Probationers' Accommodation and Social Life

There is no space in this short review to dilate upon the report of the Rockefeller Committee on this aspect of a nurse's training. One statement impressed me very much: "No Training School of the group studied has as yet provided single rooms for all its students." Privacy for a probationer is quite as desirable as 45 hours' instruction in Bacteriology.

It appears very doubtful if the recommendations of the Committee either as regards the shortening and intensifying of the curriculum or the provision of a lower grade of nurse will meet with the approval of the Medical and Nursing Profession in the United States. It is almost certain that they will not be approved in England. Nevertheless, the report of the Rockefeller Committee is such an important piece of investigation,

and such a stimulating document that, as has been said above, it should be read by everyone who is interested in the training of nurses in any country.

(To the Editor of "The World's Health"

Dear Sir:—It is not with the deliberate intention of trying to act the alleged part of Canada, that of "interpreter between England and the U.S.A.," that I am writing you regarding Dr. Eason's article in the August number of "The World's Health", but rather that this article constitutes a challenge to those who are interested in the training of nurses. In this instance, nevertheless, I believe it happens that the consensus of thought among Canadians within both the medical and nursing professions, might be said to be midway between the experiments recommended by the Rockefeller Report, and the training of nurses recommended by Dr. Eason.

In so far as the Rockefellr Report might appear to glorify nursing as a highly educated and self-sufficient profession without special regard to the service motive which has made it possible to recruit the finest type of women for nursing, we must take exception to it. That, in my opinion, is the great weakness of this document.

The appeal of service which nursing makes to the spiritual forces in a young woman is the deciding factor which draws her into the nursing profession rather than into some more lucrative and pleasing calling. Because this motive is strong, the nurse is able to perform lowly tasks for the sick, and to feel no hardship in a course of training which follows the "apprenticeship" method. She enters the training-school with a realization of the fact that her education as a nurse must take second place in a case of conflict between it and the care of the patients in the hospital.

On the other hand, we see no evidence of a realization of this powerful motive in Dr. Eason's thought. It would appear that his idea of a nurse is a thoroughly trained automaton whose only lode-star is obedience. It is a characteristic feature of the modern young women in this country, at least, that she does nothing blindly. She insists on thinking for herself. If she chooses nursing as her profession, she does not see any necessity for suspending her processes of thought. She believes that her intelligence is a gift to be used for humanity, and she uses it. She has no notion of trying to usurp the domain of the physician; that is, the diagnosis and treatment of disease, but she has great respect for her own part in the healing of the sick; that is, the expert administration of nursing care, accurate, intelligent and discriminating observation of the patient's condition, and the constant giving of her sympathetic understanding to inspire her patients with confidence and hope. Be very sure that this young woman does not consider she is working for the doctor. She has very definite ideas that she is working for sick people. She is endeavoring to give to the physician intelligent co-operation rather than blind obedience. If she has a disciplined mind, there will not be the slightest friction between her and the physician whose orders for the patient she is carrying out, provided that he, too, has a disciplined mind.

It is quite possible that the type of training Dr. Eason recommends would turn out good institutional machines, but I am wondering what would happen to the nurses who go out into the small towns and rural communities of Canada with this equipment. The nurse who had all initiative and resourcefulness trained out of her would find herself in a sorry plight when the nearest physician was anywhere from twenty-five to fifty miles distant, with the pos-

sible additional circumstances of bad roads and bad weather. It is a fact that work which defies criticism is being carried on in the Red Cross Nursing Outposts which are established in outlying, sparsely-settled rural communities in this country. The doctor calls when possible, but between his infrequent visits the nurse carries on. I think we may boldly claim that an alert mind is a prime requisite for such a nurse.

Nowadays, an enlightened public demands not only scientific care of the sick, but also the adoption of measures for preventing sickness. To promote the latter, we have simply to appropriate the discoveries of medical science. Fortunately, there are no mystic walls built up around these, and no "high priest" is necessary to deliver them. In the field of public health, it is hard to imagine the obedient automaton as a successful teacher of personal hygiene, because this is work which requires a resourceful and strong personality, backed up by an intelligent grasp of the subject.

One can perhaps sympathize with Dr. Eason's feeling of numbness on reading the curriculum outlined in the Rockefeller Report. To be sure, the curriculum of the student nurse has, for some years, provided opportunities for criticism, especially on the part of the medical and surgical staff of the hospitals. I think the way this criticism has been met and overcome in Toronto will bear telling.

In Toronto a centralized scheme of teaching student nurses was worked out during the war and has been in effect ever since. A Training School Committee, composed of the Superintendent of Nurses of each of the eleven schools, is responsible for the planning of the education of some eight hundred and fifty student nurses. This committee holds conferences with the members of the Faculty of Medicine of the University of Toronto and all the physicians and surgeons who assist with the teaching in the city training schools. These conferences provide an invaluable opportunity of studying the curriculum as a whole, and of making certain adjustments where there is evidence of overlapping. The careful study thus given to the curriculum, through the medium of these conferences, has corrected the impression formerly held by some of the members of the medical profession that the schools were endeavoring to give a poor course in medicine rather than a good course in nursing.

Rather big and useful things can be accomplished through intelligent co-operation.

JEAN E. BROWNE,
President, Canadian Nurses' Association.

A new justification of the skyscraper is being put forth by Dr. Edward P. Davis, an American who headed the volunteer medical service corps during the war. He claims that the higher stories of skyscrapers are among the best of health resorts. "It is obvious," says the New York "Post" in commenting on this theory, "that in the upper strata of a city's atmosphere, pierced by the high buildings, there is more sunlight and the air is purer. Painstaking research has revealed that microbes seem to obey the zoning laws faithfully and diminish in numbers as they ascend toward the apex of one of the lofty pyramids of modern cities. One of the results of aviation will be the use of the rooftops, in a striking reversion to the Oriental custom that finds the whole cycle of existence lived at the summit of the house. The soaring shaft to be reared by the University of Pittsburgh or the thousand-foot edifice to be erected in Rome, is typical of an age that spurns the ground and seeks the sky for practical reasons and not merely in epic obedience to a spiritual impulse."

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
Miss ELSIE WILSON, Prov. Dept. of Health, Winnipeg, Man.

Making the Country Safe for Children

(Concluded)

TALIAFERRO CLARK, Surgeon, United States Health Service

Measures Applicable to Rural Conditions

It is not easy to say what form of child health supervision should be undertaken in a given rural district. Much will depend on the resources of the state or provincial boards of health and their ability to give assistance, the existence or otherwise of local boards of health and their efficiency, the size of the district, the density of the population, the average wealth, intelligence and education of the citizens, and the health problems most in need of attention.

To those speaking from the profundities of academic knowledge and with the wisdom of inexperience the task may appear simple, but there is no royal road to success in such districts. Methods and measures which give good results in cities, in incorporated towns, and even in thickly settled rural areas cannot be employed successfully for the scattered rural population. Our knowledge of the principles of maternal and infant hygiene is ample, but the personnel and facilities for the application of this knowledge are lacking. Prenatal clinics, child health centers, intensive school health supervision, and other similar measures of tested worth are possible and effective, as a rule, directly as the density of population.

(1 Prenatal and Infant Care

A study of the vital statistics, when these are available and reliable, will quite frequently indicate the line of attack in prenatal and infant care.

On comparing the rural and urban maternal death rates from puerperal causes, per 1,000 live births, in the birth registration area, as of 1921, it is found that the percentage of maternal deaths in urban communities is greater than that in rural, both from puerperal septicemia and from other puerperal causes, the greatest being from puerperal septicemia. On the other hand, a rate of 3.4 from other puerperal causes as compared with 2.0 from puerperal septicemia in rural districts, emphasizes the importance not only of the employment of public health nurses and other measures to prevent infection, but also the provision of better obstetrical and lying-in facilities.

These indications are best met, in the writer's judgment, by a more extended public health nursing service rather than by the establishment of prenatal clinics and infant conferences, and by the provision of hospital facilities on a community or district basis, as is already being done in some of your provinces. The possibilities of improvement in rural health conditions through the maintenance of small hospitals in rural districts is receiving more and more attention.

(2) Pre-School Child

The health problems of the pre-school child largely centre around the prevention and correction of physical defects, protection against communicable diseases (including immunization), and the maintenance of proper nutrition. The pre-school programme in one of our predominantly rural states calls for districting the state with a state nurse in charge of each district, the employment of one or more nurses in each county, the utilization of volunteer aid and organizing groups of women in each town and precinct into permanent health

groups for house to house visits, organizing other groups of women to act as aids at conferences, and holding child conferences once each month at not less than four points in the county. Where the districts are large, the population scattered, the number of available trained workers limited, such a plan for child health conferences, while offering many possibilities for health instruction, should not be considered other than supplementing the work of the public health nurse in the home.

The success of child health conferences depends on the ability of the mothers to attend, and the regularity of their attendances. In many districts chief reliance must be placed on home visits by the public health nurse, and in others the pre-school work may with profit be linked up with school health supervision.

(3) School Health Supervision

Approximately 60 per cent. of the school children of the United States is enrolled in rural schools. Probably a comparable situation exists in Canada. The majority of these children are without any form of health supervision whatever. Not only is the need for such supervision very great, but also the work in this field is most valuable because it offers the readiest approach to the solution of many of the child health problems. One of the most striking examples of this value, with which the writer is acquainted, may be noted in one of the rural counties of Virginia, where child health supervision had its inception in school medical service furnished by the county health officer, assisted by a public health nurse. From this beginning the child health activities have extended to all forms of infant and child care, including dental prophylaxis and correction. In other words, the school became a centre of information and service from which the knowledge and appreciation of health values spread to the homes with fruitful results. School health service is frequently and probably the best beginning for rural child health work because of the close association of the school with the homes, and the need of teaching the rising generation the observance of proper health habits and the principles of personal and general hygiene. The schools offer special advantages in this respect because the representatives of so many families in attendance are thereby more accessible for examination and health instruction.

Unfortunately, health work in rural schools is confronted by two serious difficulties: (1) the lack of personnel for adequate medical inspection; and (2) the absence of facilities for correcting hampering physical defects.

The logical steps to be taken to make rural school work effective may be considered as: (a) the abolition of school districts and the establishment of larger school administrative units such as on a county basis; (b) the consolidation of rural schools which will do away with the generally unhygienic one- and two-room schools, and cause large numbers of children to assemble in buildings constructed in accordance with the more recent knowledge of school sanitation, and where it will be possible, and certainly more economical, to maintain effective health supervision; and (c) the organization of full-time county or district health units for all forms of health work, including school health supervision.

At present, and probably for a long time to come, the only form of school health supervision possible in most of the outlying districts will be that furnished by the public health nurse. The limits of this paper will not permit the outline in detail of the work of the public health nurse in this particular field. However, the duties and responsibilities of the school nurse have been described by the writer in a paper published in the "Weekly Health Reports," September 8, 1922. Reprints of this paper may be had on application to the Surgeon General, United States Public Health Service, Washington, D.C.

Securing the correction of physical defects is the most difficult of all the problems confronting the rural school health worker. These difficulties may be solved, in part, by the establishment of small hospitals in rural districts, as mentioned elsewhere in this paper, by subsidizing medical service in sparsely settled districts at state expense, and by organizing mobile dental, refraction, and ear, nose and throat clinics—a procedure now being carried out with signal success by the North Carolina State Board of Health, and elsewhere, on a less extensive scale by some of the volunteer agencies.

In conclusion, it is well to emphasize that for the present the well trained public health nurse must be considered the principal factor in child welfare and health work in a large number of rural districts. Whether she shall be qualified by training and experience for special forms of child health work or fitted by broad instruction for general public health nursing service has been the subject of anxious inquiry. In the writer's opinion the average rural community is no proper field for specialized public health nursing. The instruction given at recognized nurses' training schools, both in the United States and Canada, when supplemented by a public health nursing course or practical experience in the field, should be ample to qualify the right sort of nurse for effective child health supervision in these areas.

Working from the school as a centre, giving part-time bedside care and instruction in needed cases, instructing the mother in prenatal care and the importance of prophylactic treatment of infants' eyes to prevent blindness, impressing her with the value of birth registration, and the necessity for breast feeding, familiarizing her with the selection and preparation of foods for older infants and pre-school children and maintaining some degree of school health supervision is the broad programme for the successful rural nurse. Training will acquaint her with the fundamental principles of her work. No one can tell her in advance how to apply them to a given community. Only experience, knowledge of community needs, native intelligence and adaptability will enable her to solve the problems confronting her.

Notes on Current Literature of Interest to Public Health Nurses

Child Welfare

Part 3—Care in Selected Urban and Rural Communities. (Children's Bureau, Washington, D.C.)

Report of Standards of Care for Convalescent Children: Kahn. (Sturgis Research Fund of the Burke Foundation, New York.)

"Outline of Standards and Methods," for a Child Welfare Programme. (New York Diet Kitchen Association.)

The Pre-school Child from the Standpoint of Public Hygiene and Education: A. Gessell, Ph.D., M.D.

Child Placing in Families: Slingerland. (Russell Sage Foundation.)

Mothercraft

The Mothercraft Manual: Reade.

The Healthy Baby: Dennett, M.D. (The MacMillan Company.)

My Little Child's Health. (The American Child Health Association—10c.)

Health Education

A Programme for Public Schools and Teachers.

Training Institutions—A Report on Health Education published by the Joint Committee on Health Problems in Education of the National Educational Association, and the American Medical Association. May be obtained from—Dr. Thomas D. Wood, 525 W. 120th Street, New York City—50c.

Medical and Sanitary Inspection of Schools — revised: Dr. Newmayer—$4.00.

My Health Book—by the American Child Health Association, 370 7th Avenue, New York—10c.

P.H. Nursing

Sanitation for Public Health Nurses: Hill.

Public Health Nursing: Gardener.

Community Health

Social Pathology. (Division of Venereal Diseases, Surgeon-General, U.S. Public Health Service, Washington, D.C.)

Department of Student Nurses

Convener, MISS M. HERSEY, Royal Victoria Hospital, Montreal

Beauty and Nursing

It is not an unusual thing when considering a profession, mode of life, or a condition, to connect it with some ideal. In times of war and battle we cannot think of warfare as separated from bravery or terror. If we consider law, we connect it with justice. A religious life is closely allied to sacrifice. Then there is the "Nursing Profession," which, we are told by several writers, deals with practical actions and ideas. This thought of the **practical** permeates almost every essay on the subject, until we finally reach the stage when we cannot think of nursing without associating it with practical things. This frequently leads one to believe that the ultimate end is attained when we reach the most practical way of carrying on our profession. Now, necessary as this spirit is, it does not satisfy us: it is cold and does not stimulate the imagination. We who are interested feel that there is an ideal which is more fitting. This ideal brings before us the beautiful in life and may be termed "beauty."

Beauty as an ideal does not dispense with the practical, but involves it. Mathew Adams has shown very clearly that one of the essential constituents of beauty is order. On the other hand, practical acts are connected with order. Hence beauty and the practical have a common relative in their attainment. We shall endeavor to show that order and practical ways tend to produce beauty whenever they are brought into play. Truly beautiful things, however, are not brought to light by these two factors alone, as we shall see later.

Let us see what the ideal beauty really means and how it affects us. It has two sides, namely, the material and the intellectual. Materially, it appeals to our senses of sight and hearing. This is demonstrated by a large ward at inspection time as compared to the aspect that meets the human eye on "house cleaning day," let us say. At the inspection hour the beds are smooth and in order—like so many soldiers standing on guard. The patients are reclining on soft snowy pillows; chairs and bed-side tables all have their place in the symmetry of the ward. The patients, because they feel more comfortable, are more cheerful. In fact, a pleasing sight meets the eye, and pleasant sounds float gently to the ear, causing us to realize that beauty is again reigning.

There is not a nurse who has not noticed the contrast between a child from the streets and that same child in a week's time. The poor little fellow has grimy hands and face. His hair is matted and torn, so that even the color is lost. His dirty little toes are peeping through shoes that have lost all shape. His suit is ragged and worn: in short, he is a ragamuffin. This is the condition in which he has been found by the nurse. She has been taught how to deal with such cases. The usual orders and regulations of the standard hospital are brought into play. The

little fellow is cleaned outside and in. He is given proper food and rest, and in less than a week the nurse has something to show for her work. She feels a sense of satisfaction when she sees a visitor pause at the child's bed and hears the remark, "What a beautiful boy!"

We have spoken of the material side. Now let us consider for a moment the other.

Beauty appeals to the moral and intellectual senses as well. If it did not it could not be a fitting ideal. John Keats tells us that:

"A thing of beauty is a joy forever,
Its loveliness increases: it will never
Pass into nothingness."

Beauty, then, is something everlasting and eternal. When we speak of eternal things we are treading on divine ground. We have reached the highest possible state.

Divine Beauty and Divine Love are very closely connected. They go hand-in-hand through the corridors of life. Whenever an act is performed by love its expression is found in beauty. Love, then, is the other great factor necessary to bring out true beauty.

John Ruskin has given us some thoughts that bear out the above. In his "Description of Nature," from "Modern Painters," he brings before us the link between earth and man. He relates how God, by His love, has made daily preparation of the earth for man, with a beautiful means of life. This, surely, is very fitting in our profession. If we could only realize that our daily tasks are instituted by love—no matter what they are— there is always a beautiful means of performing them; then, we should find great success in life.

The hospital ward is always on hand to furnish us with illustrations, for in it are to be found the comedies and dramas of the world.

An old man of about seventy winters has just been picked up on the street. For a couple of years he has been "ailing," both in body and in mind. The neighbors have ceased to notice him, since he lost his friendly smile. He is a lonely old man without any family and no one to look after him. The "weak turn" was really a blessing for it caused a passer-by to notify the "proper authorities." The hospital is all very strange and unusual to him. At first he does not realize, nor does he bother to inquire, where he is. A sense of comfort comes to him and he falls into a peaceful slumber. A little later a kind voice inquires about his welfare and a gentle hand is placed on his brow. The little man is thrilled by a sense of some one interested in him and he responds to the touch of love.

Several weeks pass by and the white-haired man has bloomed under the wing of love. He once more takes an interest in life and becomes again a person everyone delights in meeting. His soul was not touched by mechanical means, but by the influence of love. For him the earth is again beautiful, and this is radiated in his countenance. Hope has come to him and he dreams of Everlasting Beauty.

Order, practical ideas, and love working together produce a beauty whose field is infinite. This thought is very necessary for a nurse, for with it she is able to aspire to something higher. If the material side seems empty or monotonous there is always the mystic land of the intellectual world to wander in. There ideals are truly beautiful and fraught with all our hopes.

I. E. SIMPSON,
Victoria General Hospital,
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Canadian Army Medical Nursing Service

National Convener of Publication Committee, C.A.M.N.S.,
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Reminiscences of Service

It is requested that under this heading short incidents and anecdotes will be contributed by ex-nursing sisters. Material may be sent either to the Provincial representative or direct to 410 Sherbourne Street, Toronto, Ontario.

A Memory—1915

It was midnight on the "Kildonna Castle" in October, 1915, and seventeen nursing sisters, a few medical officers and orderlies and the ship's crew, en route for Gallipoli, were silently pushing their way through the black waters of the Mediterranean.

No one thought of sleeping—each kept watch with those at the helm as they peered into the darkness and scanned the depths for they knew not what. Ugly rumors of mines and submarines filled their thoughts, and tales of other boats sunk and hidden haunted their memories. A cool breeze blew up and extra coats and sweaters were added under the combersome life belts and other "impedimenta" worn by all. Can history ever do justice to those captains and their staff who night after night bore this suspense, guiding their ship through unfamiliar ways bent on reaching some distant port by daybreak? Such heroes, unproclaimed and unobserved, have made history.

In the distance was heard the sound of guns, the roar of cannons rent the air and shook the ship, seeming to lift it for a moment into space to hurl it back again as it sped through the water. It was a never-to-be-forgotten night; a holy night when no one thought of self or selfishness, but looked eagerly for the morn when those on shore, sick and suffering, could be brought on board and tended and the weary given food and rest.

Biographies—A Suggestion

A timely suggestion has been made by one of our returned nursing sisters, who proposes "that we devote a certain portion of our C.A.M.N. Section each month to the biographies of those of our comrades who lost their lives during the world war and of those who have directed the policy of Army nursing since its inauguration." It is with deep appreciation that we acknowledge this suggestion and we will endeavor to start a series of short articles next month.

It is most fitting that in the History of Canadian Nursing, the lives of those who have been prominent in directing the care of the sick in times of war should hold a significant place. The life of the first Army Nurse, the founder of our profession —Florence Nightingale—is known to

us all. The traditions of Army Nursing date from the time of the Crimean war in 1853. Previous to this date it has been stated that the arrangements for taking care of the victims of war were most inadequate. The Crimean campaign was the first war to be fought under the searchlight of newspaper publicity and all Europe was informed of the existing conditions. It was at this time that the British Secretary for War made arrangements for sending Florence Nightingale and twenty-eight nurses to bring about a better state of things. Florence Nightingale was a woman gifted with deep sympathy and high intelligence. All her life she had wished to devote her natural abilities—and later on her trained abilities—to the proper care of the sick and suffering. For this work she had qualified herself, and here was her opportunity. She brought order out of confusion, earned the fervent gratitude of the wounded and of their relatives at home and set for all subsequent times a high standard of personal service in the care of the sick and wounded in war. It is to such nobility of purpose and upon such a code of honor that the ethics of Army Nursing in Canada are founded.

BRITISH COLUMBIA

A very enjoyable re-union was held by the Nursing Sisters' Club of British Columbia on Armistice Eve. Sixty-three nursing sisters met at dinner. The tables were attractively decorated with poppies and chrysanthemums; the place cards with original verse and limericks caused much amusement. The toast list was as follows:—"The King," "O Canada." "Our Club"—Proposed by Miss Pauline Rose; response, The President, Miss J. Matheson. "The Matron-in-Chief"—Proposed by Mrs. Clayton; response, Mrs. J. B. Rose. "The C.A.M.C."—Proposed by Mrs. Shepperd; response, Miss Jane Johnston. "Our M.O.'s"—Proposed by Mrs. Heyer; response, Mrs. MacDonald. Old-time favorite war songs were sung between courses and an informal dance followed the dinner. A number of outside guests came up from Victoria and other points on the Mainland and Vancouver Island. After dinner friends came in to join in the dancing, which was indulged in until midnight.

On Armistice Day at 11 o'clock a cross was placed on the Cenotaph by Miss B. MacNair, representing the Nursing Sisters.

News Notes

Matron M. M. Goodeve, R.R.C., has recently taken a refresher course at Sloane Maternity Hospital, New York. Immediately she was offered, and accepted, an important appointment on the staff.

Matron J. M. Macdonald, R.R.C., is at present on the nursing staff of the Cowdray British Hospital, Mexico City.

The Montreal Canadian Overseas Nurses' Association held their annual At Home in the reception rooms of the nurses' residence of the Royal Victoria Hospital. The guests were received by Nursing-Sisters Wattling, Upton and Enright. After bridge and Mah Jong, refreshments were served. About seventy nurses were present and spent a very pleasant evening.

Miss Lillian Pidgeon, R.R.C., has resigned her position at the Royal Victoria Hospital and after a short holiday will go to Nassau Hospital, Mineola, as Assistant Superintendent.

Miss V. E. Sampson has resigned her position as Matron of the Red Cross Lodge, Montreal.

Miss M. Patterson, who has been in charge of the operating room, Vancouver General Hospital, has returned to Montreal, to the Royal Victoria Hospital as nurse in charge of the Main Operating Room.

News Notes

ALBERTA

EDMONTON

On Saturday evening, December 17th, the spacious reception rooms of the Nurses' Home were alive with light and merriment, when the members of the school and their friends were entertained at a Christmas Dance. Miss Guernsey, Superintendent of Nurses, received the guests. Christmas trees and bunting, together with the strains of the all important orchestra, completed the success of a most enjoyable event.

On the evening of December 1st, 1924, the members of the first class of students taking the Bachelor of Science in Nursing course at the University of Alberta Hospital, having completed their preliminary course, received their caps and were formally accepted by the Council of the School of Nursing.

The annual formal reception given by Miss McCammon and members of the School of Nursing was held at the University of Alberta Hospital on December 26th, 1924.

Miss A. E. Little, Assistant Superintendent of Nurses at the University of Albert Hospital, is at present enjoying her vacation in Eastern Canada.

SASKATCHEWAN

The Saskatoon Graduate Nurses' Association held its regular monthly meeting on Monday, January 5th, 1925, in the St. Paul Hospital Nurses' Home. Following the business meeting, Mr. Claude E. Lewis gave an address on "Personal Impressions of Oxford". Refreshments were served by the Sisters.

The Saskatoon Nurses' Association gave a Christmas Tree and supper at the Y.W.C.A. on December 23rd to twenty-five children of the Day Nursery, accompanied by their mothers and members of the Day Nursery staff. Every member of the Association lent able assistance in making this a most successful affair.

Miss Elizabeth H. Stirling, Reg. N., Superintendent of the General Hospital, Weyburn, resigned her position, her resignation taking effect on the first of the New Year. Miss Stirling visited friends in Weyburn for a few days before her marriage, which took place early in the New Year.

Miss Beatrice M. Auld has been appointed Superintendent of the Weyburn General Hospital. Miss Auld is a Graduate of the Weyburn General Hospital, and was for a number of years the Superintendent of the Union Hospital, Rosetown, Saskatchewan.

Mr. and Mrs. Arthur Freeman (nee Jessie M. Macleod) were recent visitors in Regina, on their way to Eastern Canada wrere they will visit for a few weeks before taking up their new home in Hollywood.

ONTARIO

Thunder Bay G.N.A.

The monthly meeting of the Thunder Bay Graduate Nurses' Association was held at the Nurses' Home of the Port Arthur General Hospital on Thursday, January 8th, when a large attendance heard an able lecture on "Tubercolosis" by Dr. J. I. Pratt, of Port Arthur. At its close the Doctor gave a most interesting talk on his recent visit to Europe. Songs were beautifully rendered by Mrs. Kioby. The serving of dainty refreshments concluded the meeting.

TORONTO

Toronto General Hospital A.A.

The annual meeting of the Social Service Association of the hospital was held on January 13th, at "Holwood," Queen's Park, the residence of Sir Joseph and Lady Flavelle. In her remarks Mrs. F. Y. McEachren, President of the Association, paid generous tributes to Miss Gunn and the department, with Miss Knisely as head worker; to the Federation for community service for the financial assistance given annually; and to private citizens who give their time and money to help in the work. Miss Knisely in her report showed that the past year had been one of genuine accomplishment. The conveners of the various committees gave their reports, and Mrs. W. B. Hendry, Treasurer of the Association, presented a very gratifying financial statement. An interesting address was

given by Miss Lena R. Waters, of Chicago, Secretary of the American Association of Hospital Social Workers, with which Eastern Canada is affiliated. Preceding the meeting Mrs. Harold F. Ritchie (Miss Berba Brydon, 1907) entertained at the King Edward in honour of Miss Waters. The guests included the Executive of the Association, Miss Locke, Miss Russell, and Miss Tupper, of New York.

Through the generousity of Mrs. D. A. Dunlop, who sent a Christmas cheque to the nurses of the hospital, Miss Gunn arranged a dance and bridge party for the school on December 30th, which was enjoyed by all—graduates, student nurses and their friends.

Miss Elsie Bain (T.G.H., 1920) has been appointed Treasurer with Miss Eva Christie in place of Miss Dorothy Galilee, who resigned in December.

Miss Jean Gillis (1921) has gone to New York, where she intends to do private duty nursing.

The Misses Helen Hill, Meta Greutzner and Lois Smith (1923) have left for New York to do institutional work in the New York Hospital.

Miss Jean Young (1924) is in charge of Ward "D" of the Toronto General Hospital.

Western Hospital A.A.

The annual Christmas tree and supper given by the hospital in connection with the Out-Patients' Department was enjoyed by one hundred and fifty children. After disposal of the articles on the Christmas tree by Santa Claus, carols were sung by the children.

Miss Floyd and Miss Stevenson (1914) have gone to New York to do private nursing.

Miss Laura McDougall (1918) has taken charge of the private wards, succeeding Miss Floyd.

Miss Hewitt (1924) has taken charge of one of the private floors.

Miss Opal Hill (1918) has resigned her position as supervisor of private wards.

Miss Margaret Johnston (1920) has resigned her position in the Outdoor Department and is leaving for Calgary, where she has accepted a position in Social Service work.

At the monthly meeting of the Alumnae Association, Miss Mary Thomas was appointed to act on the visiting committee, in place of Miss Floyd, and Miss Lowe as the representative to "The Canadian Nurse."

The new "Alexandra" Obstetrical Wing was formally opened on the evening of December 30th. After the reception an enjoyable dance was held in the Auditorium.

Hospital for Sick Children A.A.

Miss Alice Grindlay (1914) is in charge of the Children's Ward, Montreal General Hospital.

Miss Gertrude Spanner (1914) is instructor of nurses at the new Civic Hospital, Ottawa.

Miss Esther Beith (1914), who until this autumn was Director of Infant and Child Welfare work in the Public Health Department, Toronto, is now stationed in Halifax as Director of the Child Welfare work in connection with Dalhousie University.

Miss Mamie Dennison (1917) is Assistant Superintendent of Nurses at the Victoria Hospital, London, Ont.

Miss Sue Smythe (1916) has left for Montreal, having accepted the position of Assistant Superintendent in the Shriners' Hospital for Crippled Children.

Miss Marjorie Ferguson (1918) has been in Pasadena, California, for the last year doing private duty.

Miss Marion Ruddick (1915) has returned from London (Eng.) and is at present in Ottawa.

Miss Elliott (1919) is at present Night Supervisor at the Hospital for Sick Children, Toronto.

LONDON

A.A. Victoria Hospital Training School for Nurses

A very large number of the members of the Victoria Hospital A.A. attended the January meeting (a social evening) held at the Nurses' Residence. A short, encouraging and optimistic address was delivered by the President, Miss Agnes Malloch. The presence of Miss Grace Fairley, Honorary President, Superintendent of Nurses, and members of the graduating

class 1925, added to the pleasure of the evening. Much merriment was created by the participation of all present in a delightfully original programme, arranged and directed by Mrs. Pearl Allison, ably assisted by an enthusiastic committee. Several prizes were awarded individuals and groups for various unique contests requiring rare mental, physical and masticating abilities. Competition was keen. Piano selections were artistically rendered by Miss Della Foster, who also played "Oh Canada" as an accompaniment to the marches of the nurses, "Ancient and modern." A thoroughly enjoyable evening was concluded by the serving of light refreshments.

Miss A. E. McKenzie is Office Nurse with the Drs. Harkins, of London, Ontario.

SARNIA

A.A. Sarnia, General Hospital

The General Hospital graduation exercises were held in the auditorium of the Technical School on Friday evening, October 24th, 1924, when the following five nurses received their diplomas: S. Laugher, D. Shaw, V. Lavern, J. Watson, B. Eastman. After the exercises a reception was held in the gymnasium. On October 24th, 1924, the Alumnae entertained the graduating class at a dinner given at the Patricia Cafe, when thirty members of the Alumnae were present.

On November 11th, 1924, the Alumnae gave a dance in the town hall, which was prettily decorated for the occasion with flags, autumn leaves, balloons, etc. A most enjoyable evening was spent by all those present.

In October, Miss Scott, honary president, returned from a delightful three months' trip abroad.

Miss C. Johnson and Miss I. Sutherland, S.G.H. graduates, have left on an extended trip to Florida.

Miss R. Wade (S.G.H. 1923) has accepted a position in McKellar Hospital, Fort William.

The Alumnae Association meets in the classroom, Nurses' Home, George Street, on the second Monday of each month.

BRANTFORD

A.A. Brantford General Hospital

The Brantford General Hospital Alumnae Association held their annual bazaar on Wednesday, November 26th, 1924, at Grace Church Parish Hall. The attendance was fair and about one hundred dollars taken in. Miss Bartley was in charge of the tea room with Miss Ford and Miss McKee pouring tea and coffee. Mrs. Millard had charge of the fancy work booth, Mrs. McHardy the home made candy, and Miss Hough was in charge of the dancing.

BELLEVILLE

A.A. Belleville General Hospital

Miss Bessie Allen (B.G.H. 1922) has accepted the position of Matron in charge of the Isolation Hospital, Belleville, Ontario.

Miss Flossie Hannah (B.G.H. 1923) and Miss Kathleen Barker (B.G.H. 1924) have accepted positions at the Midlowan Hospital, New York City.

Miss Anne Seeney (B.G.H. 1923) is on the staff at Grassland Hospital, New York City.

Miss Bertha Goodwin and Miss Sadie Brockbank (both B.G.H. 1924) have accepted positions at the Alexandra Hospital, Montreal.

HAMILTON

St. Joseph's Hospital A.A.

After the mid-night carols had ceased and Santa had taken his departure, the hospital corridors and wards relapsed into profound silence until the glad bells announced the time for mid-night Mass.

Three Masses were celebrated by Rev. Father McHugh, who having wished the congregation the joys and blessings of the holy season afforded the sick the consolation of distributing to them the Bread of Life.

During the day the Hospital was the scene of real merriment as patients received their visitors in a steady concourse. The greatest pleasure of the day was a visit from His Lordship the Rt. Rev. J. T. McNally D.D., whose presence in the hospital brought joy and gladness to those who were privileged to meet him. The Sisters thank all who contributed to allay

the sufferings and increase the happiness of those who were unable to spend Christmas with the dear ones at home.

Miss B. Kelly (St. J.H. 1924) has been appointed Day Supervisor, Floor "C", St. Joseph's Hospital, Hamilton.

Miss M. Kennedy (St. J.H. 1924) has been appointed Night Supervisor at the Maternity Hospital "Casa Maria."

The senior class in training at St. Joseph's were guests of the Alumnae recently at a delightful sleigh ride. Two "sleighfuls" of nurses participated in the ride and later partook of refreshments at a downtown cafe. Mrs. Arthur Kelly was in charge of the party.

QUEBEC

MONTREAL

The General Hospital A.A.

The 1925 class, M.G.H., are editing the first "Year Book" of the training school.

Miss Birkett Clark has taken charge of the Fisher Memorial Hospital, Woodstock, N.B.

Misses Christina Mackay (1922) and Ida B. Merkley (1919) have accepted positions on the staff of Lockport Hospital, Lockport, New York.

A number of our members have been patients at the M.G.H. in the last month or so.

Miss Isabella J. Brown (1923) has given up private nursing to enter the ranks of V.O.N., in Montreal.

Miss Nellie Tuck (1912) and Kathleen Faulkner (1920) have accepted positions on the staff of the Margaret Hungerford Hospital, Torrington, Conn.

Mrs. (Dr.) Stewart Ramsay (nee Joliette Pelletier, class 1914) of 248 Mountain Street, Montreal, was At Home to the members of the Overseas Nurses' Club of Montreal, recently.

The sympathy of the members of the alumnae goes out to Mrs. Dorion (nee Janet T. Rothwell) in the sudden death of her husband (Dr. Dorion), and to Miss Helen Tracey in the loss of her mother, who passed away at Montreal General Hospital recently.

Miss A. M. Becksted has been called away to Schenectady, New York, to attend a sister who is very ill.

At the annual meeting of the Montreal Graduate Nurses' Association the following M.G.H. graduates were elected to office: Misses S. E. Young, Janet Brown, Amy des Brisay, L. Parker, E. Howard, E. Cowen, Agnes Jamieson, C. Watling, C. Barrett and B. Willett.

One of the most enjoyable dances ever held at the Montreal General Hospital was that given recently by Miss S. E. Young, lady superintendent, and the members of the hospital for the nursing staff. About three hundred guests were present, including several governors of the hospital and many prominent members of the medical staff. Dancing was carried on from nine o'clock until after midnight in the nurses dining room on the sixth floor, which was attractively decorated with holly, ferns, red flowers and berries.

Miss Young received the guests, assisted by Miss J. Craig, lady superintendent of the Western Division of the Montreal General, and Miss F. E. Strumm, assistant to Miss Young.

The M.G.H. A.A. held their 18th annual meeting on the evening of Friday, January 9th, and gave a good report of progress made in 1924. Officers were elected for the ensuing year and the principal item of business was a decision to hold themselves responsible for a scholarship to McGill this year.

A.A. Royal Victoria Hospital

At the annual meeting of the Alumnae Association held on January 7th, officers were elected for the ensuing year.

The annual dance given by Sir Vincent Meredith for the nurses and staff of the Royal Victoria Hospital was held at the Ritz Carlton Hotel on Monday evening, January 19th, when about four hundred guests were present.

Many R.V.H. graduates will hear with regret of the sudden death on December 24th, 1924, of the Reverend Father McCarthy, for many years R.C. Chaplain at the hospital.

Dr. Harry Pavey, a member of the medical staff, also passed away suddenly on January 2nd, 1925.

V. O. N.

The Executive Council of the Victorian Order of Nurses for Canada met in Toronto, November 17th, in the Assembly Hall of the Gage Institute, and the following members were present: Mr. C. A. Magrath, President, Ottawa; Honorable Mr. Charlton, Honorary Vice-President, Toronto; Mrs. R. W. Reford; Miss Muriel Galt and Mrs. H. S. Birkett, Montreal; Mrs. J. B. Fraser and Miss E. Smellie, Chief Superintendent, Ottawa; Mrs. A. J. Arthurs, Mr. H. H. Love, General Fotheringham, Mr. Capreol and Mr. Hewitt, Toronto, and Dr. H. W. Hill, London.

On November 18th some members of the Executive Council—Mr. Magrath, Mrs. R. W. Reford, Miss Galt, and Miss Smellie—met the members of the Hamilton local association and representatives from the local association of St. Catherines—Miss Newman and Miss Stevens—and from Dundas, Mrs. Grafton. The meeting was conducted at the Victorian Order Centre, 29 Augusta Street, Hamilton.

During the month of November a very flourishing Well Baby Clinic was organized, and is being conducted under the direction of the Victorian Order nurse, Miss Leila Wilson. The clinic is making very encouraging progress, and is well supported by the people of Arnprior.

Miss Mary Ririe, nurse in charge of the Victorian Order district of Huntsville, Ontario, reports the commencement of Home Nursing classes, and a Girl's Health League.

Miss Mary L. Boswell, Supervisor, is making a survey of the Victorian Order work in Western Canada, having spent some time in Winnipeg, Saskatoon, Edmonton, Calgary, and is now enroute for British Columbia.

Miss Smellie, Chief Superintendent, visited the local Associations V.O.N., of Cornwall, Guelph, Whitby, Hamilton and Toronto during the month of November. Miss Mary Stevenson, Central Supervisor, has reported upon the following districts supervised: Mimico, London, Dundas, Trenton, Huntsville, Woodstock, St. Catharines and Belleville, in Ontario.

The nurses of the Ottawa Local Association have organized a Nurses' Conference which meets monthly. At the November meeting a most profitable discussion of the problems relating to the Ottawa district was conducted, Mrs. Campbell, V.O.N. nurse, presiding, and a paper on social work was given by Miss Lambert.

A very successful tonsil and adenoid clinic at which the V.O. nurse, Miss Dell Lester, was in attendance was held in Digby, N.S. Later in the month the graduating exercises of the Mothercraft classes were held at the Academy, Dr. Read, President, V.O.N., making the presentation of diplomas.

Having found the national conference of Victorian Order nurses held in Ottawa in September very helpful, the nurses from Hamilton, Galt, Preston, Kitchener and Waterloo have been meeting monthly. The nurses find these conferences very helpful and interesting.

Miss Rose C. Nye has been transferred from the staff of the Winnipeg local Association to the district of Pembroke, Ontario.

Miss Anne McKittrick, who took the Summer course in Public Health Nursing at the University of California, Berkley, is doing special clinic work in connection with the Victorian Order activities of Calgary.

Miss Ethel Graham has given up her work on the Montreal District to take over hospital duty in the Labrador, and Miss Anne McLeod, who took the Summer course at Columbia University, New York City, has been apointed to the vacancy, Supervisor on the district of Greater Montreal.

Miss Mabel Hartling, formerly of the St. John, N.B. staff has been appointed in charge of the V.O.N. district in Whitby, Ontario, and Miss Grace Bain, formerly in charge of Whitby has been awarded a V.O.N. Scholarship and is taking the course in Public Health Nursing at Toronto University, 1924-25.

Miss Donalda Lanctot reports a new development in the nursing activities at Ste. Anne de Bellevue by assisting the doctor in making his examinations of the day scholars attending MacDonald College.

*The Hospital in Relation to the Health Deptartment

(Continued from page 72)

hospital is also a centre from which knowledge as to proper pre-natal and infant care comes for the health department to apply, and should be recognized as a co-operating agent in any plant of public health work.

The first active co-operation or linking up of the hospitals with the health department activities in Toronto dates from the appointment of Dr. Charles J. Hastings, Medical Officer of Health, in the fall of 1910, and in order to show the results achieved since then, the following statistics are submitted:

General Mortality Rate

1910 death date, 15.1 per 1,000 population
1923 death date, 11.4 per 1,000 population

This means that more than 2,000 less people died in Toronto in 1923 than would have died if the 1910 rate had been maintained.

Typhoid Fever Deaths

1910 death rate, 44.2 per 100,000 population
1923 death rate, 2.4 per 100,000 population

Tuberculosis Deaths

1910 death rate, 130 per 100,000 population
1923 death rate, 65 per 100,000 population

Infant Mortality Under One Year

1910 death rate, 139.2 per 1,000 births
1923 death rate, 63.0 per 1,000 births

This means that in 1923 some thousand less babies died than would have died had the 1910 rate remained.

Mr. President, these are but a few of the results that statistics show as having been obtained in Toronto during the regime of Dr. Hastings, with the helpful co-operation of the hospitals.

I leave them with you this morning, confident in the belief that if the hospitals and the Health Department only continue to play their part toward the building up of a better and a fitter race, then out of the troubles and difficulties of today, there will come a new day—a better social order and a nobler civilization.

*(Read before the American Hospital Association, Buffalo, N.Y., October 8th, 1924.)

BIRTHS

THOM—On July 10th, 1924, at Toronto, to Mr. and Mrs. Cecil Thom (Dot Mears, H.S.C., Toronto, 1921), a son.

GLASSCO—On Christmas morning, 1924, at Alhambra Hospital, Alhambra, California, to Mr. and Mrs. Lawrence H. Glassco (nee Ada Egan, St. Joseph's Hospital, Hamilton, 1915), a daughter (Matilda Florence). Both doing well.

MACRAE—On December 24th, 1924, at Badeck, Cape Breton, to Dr. and Mrs. William MacRae (Nan Hart, R.V.H., Montreal, 1922).

SPICER—At Canning, N.S., to Dr. and Mrs. Stanley W. Spicer (Irene Thompson, G.H., Halifax, 1915), No. 7 Canadian Stationary Hospital, Dalhousie Unit, a son (Stanley Thompson).

RODGERS—On December 13th, at 61 Dufferin Street, Toronto, to Mr. and Mrs. C. E. Rodgers (Miss Helen Skey, T.G.H., 1922), a son (Charles Lawrence).

SHANKS—To Mr. and Mrs. Harrison Shanks (C. I. Rogers, Sarnia G.H., 1914), a daughter (Betty Joan).

KERR—To Mr. and Mrs. Sam Kerr (Liddy Pressy, Sarnia G.H., 1919), a daughter.

MATSON—In August, 1924, at General Hospital, Brantford, to Mr. and Mrs. Matson (Iyla Stewart, B.G.H., 1920), a son.

HEWITT—To Mr. and Mrs. T. Hewitt (Beatrice Jennings, B.G.H., 1919), a daughter.

SILLS—On November 29th, 1924, at Windsor Hospital, Windsor, Ont., to Mr. and Mrs. Clare Sills (Helen Wyatt, Belleville G.H., 1922), a son.

MARRIAGES

MORTON — ANDREW — On December 22nd, 1924, at Regina, Christina J. Andrew (Regina General Hospital, 1919) to Harry Morton, of Lumsden, Sask.

FREEMAN — McLEOD — On December 11th, 1924, at Los Angeles, California, Jessie M. McLeod (Medicine Hat General Hospital, 1907) to Arthur Freeman, of Hollywood, Calif.

MITCHELL—STIRLING — On January 7th, 1925, at Weyburn, Elizabeth Hart Stirling (Winnipeg General Hospital, 1917) to Harry E. Mitchell, of Weyburn, Sask.

WILKINSON—BATEMAN—In June, 1924, at Toronto, Martha Bateman (H.S.C., Toronto, 1922) to Dr. F. W. Wilkinson.

ANDERSON — SLOAN — On December 20th, 1924, at Saskatoon, Bertha M. Sloan (Saskatoon City Hospital, 1924) to George W. Anderson, of Sutherland, Sask.

BEAUMONT—KERSTEMAN—On Saturday, December 20th, in Christ Church, Toronto, Mary Louisa Kersteman (T.G.H., 1918) to Basil H. Beaumont. Mr. and Mrs. Beaumont will reside at 31 Snowdon Avenue, Toronto.

JOLIFFE—HUNT—On December 23rd, at Toronto, Ella de Vere Hunt (T.G.H., 1914) to Ernest Joliffe, B.A.

KING—McCALLUM—On Tuesday, December 30th, at Port Elgin, Ont., Mary A. McCallum (T.G.H., 1918) to Sanford King, of Woodstock. Mr. and Mrs. King will live at Niagara-on-the-Lake.

LUDWIG—GASKELL—On Friday, January 2nd, at Bloor Street Presbyterian Church, Edith Gaskell (T.G.H.) to M. H. Ludwig, K.C.

SANDERS—CONNELL—On Tuesday, December 16th, 1924, at Round Hill, N.S., Kathryn Whitman Sanders (R.V.H., Montreal, 1919), to James Walter Connell.

CROZIER—HOWARD — On December 19th, 1924, at Brockville, Ont., Edna May Howard (B.G.H., 1920) to William Crozier.

McHARDY—SMITH—In August, 1924, at Buffalo, N.Y., Minnie Smith (Brantford G.H., 1923) to Robert McHardy, of Brantford.

FRANCIS — TREMAIN — On Saturday, September, 13th, 1924, at Philadelphia, Frances Martha Tremain (Sarnia G.H., 1919) to Arthur Gould Francis.

HAYES—McKINLAY — On Wednesday, November 26th, 1924, at the Presbyterian Manse, Camlachie, by the Rev. A. W. Gayley, Annie McKinlay (Sarnia G.H., 1922), to Ervin Hayes, Kimball.

GIBB—WEST—On November 1st, 1924, at the Methodist Parsonage, Thedford, Mary Emily West (Sarnia G.H., 1923), of Thedford, to Harold Gibb, of Corunna.

BADGLEY — CHANDLER — On August 2nd, 1924, at Detroit, Mich., Florence Chandler (Sarnia G.H., 1919) to Dr. Carl Badgley, of Ann Arbour.

BRISTOL—COOK—On September 21st, 1924, at London, Elsie M. G. Cook (Sarnia G.H., 1921) to Miles Bristol, of Detroit, Mich.

HALL—REID—On December 19th, 1924, at Lloydminster, Sask., Annie Gertrude Reid (Royal Alex. Hosp., Edmonton, 1919), to James Robert Herbert Hall.

DEATHS

FREELAND—On January 12th, 1925, at 285 Mountain Street, Montreal, Emily Helen Freeland (R.V.H., 1898).

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The Canadian Nurse

A Monthly Journal for the Nurses of Canada
Published by the Canadian Nurses' Association

Vol. XXI. WINNIPEG, MAN., MARCH, 1925 No. 3

Registered at Ottawa, Canada, as second-class matter

Entered as second-class matter March 19th, 1905, at the Post Office, Buffalo, N.Y., under the Act of Congress, March 3rd, 1897

Acting Editor and Business Manager:—
JEAN S. WILSON,, Reg. N., 609 Boyd Building, Winnipeg, Man.

MARCH, 1925

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